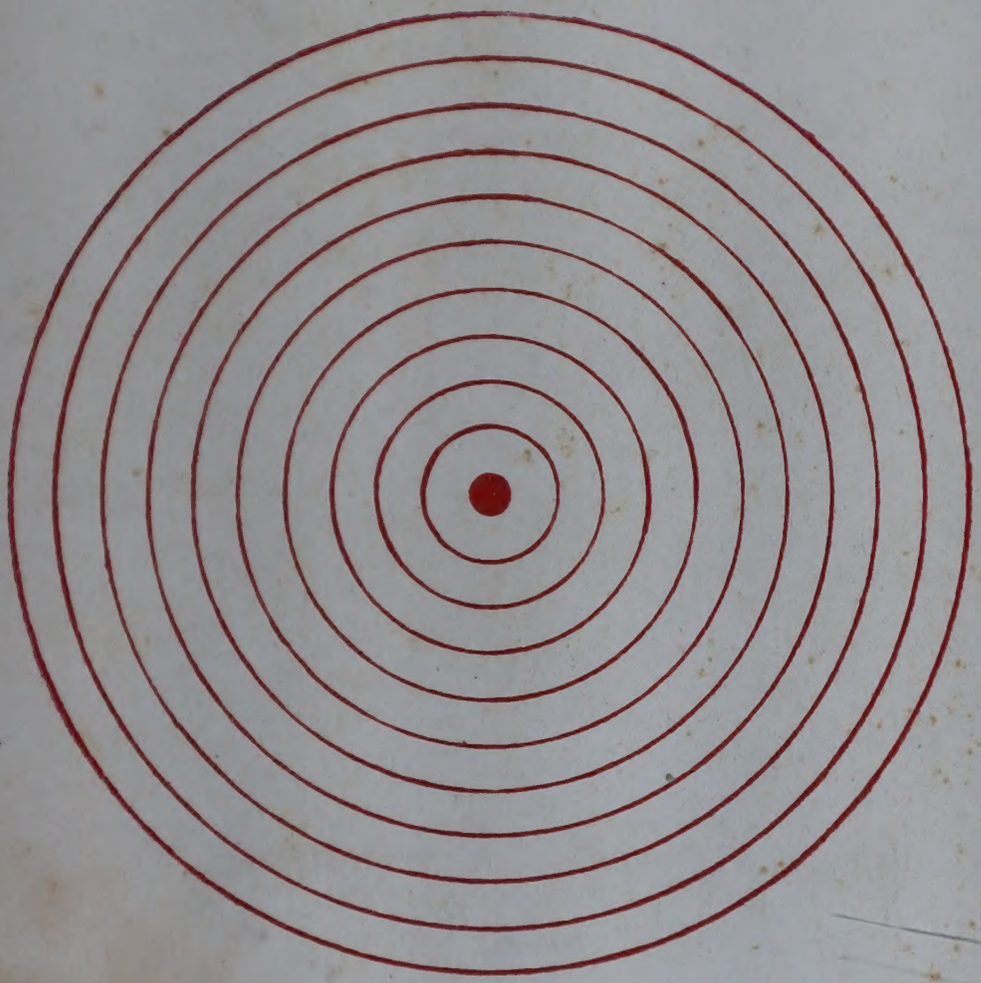
THE TWILIGHT OF THE DAWN

A Study in Retrospect



A PUBLICATION OF

CENTRE FOR RURAL HEALTH AND SOCIAL EDUCATION

TIRUPATTUR, N. A. DT.

INTRODUCTION

This document contains three parts, namely, an Inital Study Survey conducted in 1978 in the major panchayath villages in Tirupattur and Vaniyambadi Panchayath Unions and Yelagiri and Javadhi Hill tracts; an Evanluation Report conducted in 1986 by two external experts; and, a report of the Baseline Survy conducted in 1987–88.

The first part, that is, the Study Survey unfolds an objective and experiential recording of nearly 200 villages visited with duing the first nine months of CRHSEs life and work. A team of six committed young people along with some friends undertook this arduous but yet a significant task of knowing and experiencing the patterns of life in the areas of study; and problems and prespectives of people. Even today, after ten years of CRHSE's existance, staff continue to refer to the unabridged and original document for reference and planning programmes. We are grateful to the first team of six mentioned under the chapter heading who had undertaken the survey and to Mssrs Sathish Samuel and M. Ramaprasad who joined the team intermittently. We are also grateful to Mr. A. Sivasubramanian who has helped us to edit this in its present form and shape.

The second part, that is , the Evaluation Report is an effort to reproduce the original document of the evaluation conducted by two persons of standing in the field of development namely Mr F. Stephen, Director of SEARCH, Bangalore and Dr. Daisy Dharmaraj, Director of PREPARE, Madras. Even though these two were commissioned by both Christian Aid, London and Bread for the World, Stuttgart the two of our long-standing supporting partners, they were our allies in development action whose observations, interaction and conclusions were extremely useful and served as significant parametres for both reviewing the past as well as planning for the future. We are thankful to them both.

The last part, that is, the Base line Survey – an Initiative is an outcome of a strong recommendation by the members of the above mentioned Evaluation Team that CRHSE undertakes a baseline survey following definite formats and parametres to ascertain the effects to the CRHSE's programmes thus far, especially in the field of community health where the status of health in the areas of CRHSE's work can be measured as result of its historic intervention in the lives of people here. Many of our Village Level Workers who have now become autonomous undertook the actual community surveys but this initiative was planned and compiled by Dr. Prabir K. Chatterjee who is now one of the Associate Directors of CRHSE. We are thankful for all those VLWs. A special word of appreciation goes to Dr. Chatterjee. We also would like to record our appreciation to all other staff involved in this effort which is still continuing, and to Ms K. Thenmozhi for her secretarial assistance.

Thus the three parts of this document reveals not only the experiences but the achievements of CRHSE as well. As the achievements surpassed the expectation of CRHSE, the challenges turned out to be a unique experience which it liked to share with others who might be interested in development action and hence this booklet. CRHSE will also be grateful for the comments and suggestions from other organisations engaged in similar work and like-minded people for this dialogue will further strengthen community develcpment programming and organisation

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PART I

An Initial Study - Survey of Tirupattur and Vaniyambadi Areas

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PART I

An Initial Study - Survey of Tirupattur and Vaniyambadi Areas

Development is often understood in terms of target oriented and quantifiable growth. Gross National Product (GNP) and per capita income are taken to be its indices. The qualitative effects of development such as human welfare and social well-being are seldom taken into account. As a consequence of this kind of over emphasis on growth, GNP, per capita income, the development process has resulted in a widening gap between the rich and the poor; a perverted system of economic production which caters to the luxurious needs of the few rich at the cost to the basic needs of the poverty stricken masses, a publicity and advertisement dominated system of distribution which encourages conspicuous consumption by a few while millions go without even one square meal a day. The net result of all this is that man has become a forgotten factor in the whole process of development. Unless this trend is reversed and man is placed at the centre, development will be meaningless to millions of human beings.

Development should be based upon the firm conviction that man is the ultimate end and purpose of development. Development-economic, social, political or cultural should be for the benefit of the individual and for the whole community. Agricultural production, industrial progress, technological advancement, educational improvement, roads, communication facilities housing etc. are all tools for the development of the man. The former Finance Minister Mr. C. Subramaniam said recently that the six five year plans had created only the infra structure. The seventh plan should therefore be formulated from the gross-root level so that the people would make use of the achievement of earlier plans. Agricultural production, mainly the food grains yield has trebled from 50 million tonnes in 1950 to 150 millions tonnes in 1983–84. That will provide 432 grams of foodgrains per head. But people living below poverty do not have that income to eat so much, why? The majority of the rural folk living in poverty have very low income due to unemployment or underemployment, low wages, ill health, ignorance and illiteracy. The benefits of the plan have not percolated to the poor while the rich and affluent have improved their conditions. The new technology introduced in agriculture, for instance, involves heavy investment, and has greatly helped the growth of capitalist farming in India. Though the new agricultural strategy opened up vast possibilities for rural growth and development, has by-passed the large section of rural population particularly the small farmers, tenants and agricultural labourers. The rich becoming richer and the poor poorer is therefore no development.

The 'Operation Flood' project has produced more milk; but the milk producers' children are not consuming even the minimum needed milk for the normal growth. Educational institutions have been opened in order to enrol large number of children because of their ignorance and indifference. Medical facilities have been extended to villages with the starting of more hospitals, but canvassing is also necessary to induce the people to take the sick to the hospital for getting medical relief. It appears that people are neither aware of the government programme extended for their benefit, nor showing any interest in the operation of the schemes planned by government. Therefore the development plans have failed to confer benefits on the people.

The development plans were based on the Western models which had no relevance to the needs, abilities and aspirations of our people. Thus Plan schemes sponsored by government at the centre or at the states without taking into account the regional variations in potentials culture and sentiments of the people, were implemented by the bureaucratic administration handed down by the colonial government. The rural people are unaware of these development programmes due to ignorance, illiteracy and indifference.

The people of rural India live in apparent darkness. They are bound by caste, culture & superstition. They enjoy limited economic freedom. Job opportunities in the villages are restricted to agriculture and allied operations. As the people are unskilled, their productivity is low. Also they are immobile and they have learnt to live with simple enduring life, without any aspirations for improvement.

The agricultural labour in this country is confined to a particular caste. The caste system has produced among the higher caste a sort of contempt for manual labour. The low caste people doing agricultural and allied work are given low wages and lower status. The social depression has resulted in deprivation of better living. The barber or washerman in the village never thinks of shifting to other occupation. The fisherman is always a fisherman however low or high his income is. Agricultural labour would rather starve than going in for other occupation, even during the lean season. Untouchability still prevails even after four decades of freedom. Harijans still live in isolated colonies. The name 'cheri' has been changed to 'colony' but social relationship remains the same; separate drinking water facilities, separate cremation ground, seperate deities and temples, separate festivels etc. for higher caste and scheduled caste.

The story is like this. The weaker sections of the rural community, because of their poor skill and illiteracy, remain in the villages depending mainly on agriculture, which provides employment for less than half the days of the year. For the remaining period the unemployed labourers work for lower wages. Some of them bind themselves to the landlords or masters so as to secure employment throughout the year. Anyway this position is favourable to landlords or money lenders who either keep them as bonded labour or permanent debtors. The landlords who posses the means of production in the villages have command over the entire life of the agricultural workers and exploit the weakness of the low caste to their advantage, economically, socially and politically. The landless labourers do not have the spirit of enterprise and initiative. In the village set up these landlords are demigods, whose verdict on any matter concerning the life of the worker is unchallenged. The social disability combined with poverty and ignorance has blunted the process of free thinking of the weaker sections. Efforts to organise these rural backward people for raising their voice of grievance are easily thwarted by the exploiting upper castes who are comparatively better educated, economically strong and politically influential. The backward class people in the village have therefore bornewith this system patiently and seldom has come to stay. So the economic, educational or other social welfare schemes of development intended for the downtrodden have not delivered benefits but eventually went in favour of the elite among them. The affluent upper castes interfere with the family matters of the labourers by virtue of their higher social and economic status. The innocent workers approach the affluent landlords not only for money, but sometimes for advice to solve their domestic problems. The quarrel within the family of the workers comes to the landlord for settlement. It is not uncommon in villages that the upper class employers demand the women of the labourer for their sexual gratification. Arson and murder of harijan families in Villupuram and Radhapuram are instances in point.

Politically these agricultural labourers of the scheduled castes have no freedom to vote. Nor do they express their openion on any matter concerning the administration. The government officials normally call on the elite in the villages during their visit and the elites

of the villages speak on behalf the weaker sections of the community. Even if the downtrodden have any real grievance they have to represent through the landlords only.

The need for growth with social justice was realised even at the time of drafting the Fourth Plan (1969-74). It is said that "planning would result in greater equality in income and wealth, that there should be progressive reduction of concentration of incomes, wealth and economic power and the benefits of development should accrue more and more to the relatively less privileged classes of society". The broad objectives of planning could thus be defined as rapid economic development accompanied by continuous progress towards equality and social justice and the establishment of a social and economic democracy. These objectives cannot be achieved by planning and implementation of schemes at government level. The strategy of growth needs a sense of participation from those who are to be benefited by the process of development. The sense of participation can be ensured by infusing confidence in the minds of beneficiaries who must be free to express their opinion about the plan schemes. The people can express their views only when there is no social inhibition and economic repression. These downtrodden people could be inspired by changing their attitudes; by building awareness of their rights, problems and resources; and by motivating them for action to accomplish dignified means of living. Who could help these rural mass to change their attitudes and outlook in life? The government officials still following the British mode of administration do not shed down their official air and stoop down to help their own countrymen. Religions are more concerned about man's relation with and devotion to god. Politicians meet the people during election for enlisting votes. Social workers, voluntary agencies and non-governmental organisations can alone serve these poor millions without expecting any reward.

Project Location

The CRHSE is one of the institutions that has devoted its time and attitude in this direction in Tirupattur area of North Arcot District in Tamil Nadu. This area is on the North-West border of Tamil Nadu, flanked by Andhra Pradesh and Karnataka on the north and west respectively. This area is spread out in an area of roughly 3.9 lakhs acres. About one half of the area is covered by Yelagiri and Javadhi hills. The hilly forest area is replete with sandle wood and teak wood trees, interspread with spices, medicinal and aromatic plants. The north western part of this area is slopping down to form a valley with pambar stream flowing in the middle. The Palar river flows along the boundary. Over eighty per cent of the plains is cultivable. Agriculture therefore forms the main occupation of the people in the 157 villages and their hamlets. The forests of the areas is inhabited by tribals who depend on forest produce for their livelihood.

Social Stratification

The population of the area is about a million. Majority of the people are Hindus, divided into 35 castes. The prominent and domient caste groups comprise of Brahmins, Naidus, Reddiars and Marattiars. They are considered as higher caste group. The Vanniars, Chakkiliars (cobblers), Parayars (drummers), Kurumbars (shepherds), Boers(stone cutters), Navithars (barbers), Irulars (hunters), Thottiars (scavengers) are scheduled as backward class.

The people of higher castes though small in number are economically well off and possess the sizeable land areas. Some of these families migrated from Andhra Pradesh belong to Naidu and Reddy communities and speak Telugu at home. The Marattiars settled from Maharastra speak marathi. The lower caste groups form the agricultural labour force, depending on the landlords for employment and wages. They live in the cheris (now called colonies) separated from the main village where the higher caste people reside. Though most of the scheduled caste people belong to Hindu religion, they do not participate in the festivals in the temples of worship of caste Hindus. The cheri people have their own deities, cultural festivals and rituals quite different from those of the higher castes. Untouchability, though punishable under law, is still prevalent in the interior villages. Separate drinking water wells or taps have been provided for these two communities by the panchayats.

The Muslims and Christians are in the minority and are found in certain parts. Most of the Muslims are employed in the leather and beedi industries. Christians, still smaller in number, are teachers or government officials.

The tribal population of about one lakh lives in small villages scattered over the hills. The villages are not connected by proper roads. The tribals trek nearly twelve kilometers through the rough foot path to reach the nearest village on the plains, for employment or marketing. The lack of communication has rendered free mingling with the people on the plains and in the hills difficult. The tribals speak Tamil; the literacy rate is very low among them. Among the tribals also there are land owners and landless labourers. Though there are not many caste divisions among the hill tribs, marriages are conducted within the smaller groups. Each group has its own way of celebrating festivals in which others do not participate.

Economy of the Area

About one third of the population of the Taluk has been classified as workers. Among the workers nearly 47 per cent are cultivators; 30 per cent are agricultural labourers. The remaining workers are engaged in non-agricultural industrial establishment mostly in the urban areas. (Census 1971).

Since there is no regular source of irrigation crop prospects depend on rainfall. Of the total area irrigated, (12,000 hectares) tank and well irrigated area is only 5 per cent. The rest of the area has no assured irrigation. Dry crops are therefore raised in the areas where irrigation is not available. The dry crop is less productive and income is therefore poor. The low income is also not regular and unemployment is perpetual. For the past ten years rainfall had been irregular and crop failures had been common. This has adversely affected the people depending on agriculture. The marginal and small farmers and the agricultural labourers lost their earning due to unemployment. Low income and high prices afflicted these people severly. Some of them indebted to their masters, became bonded labourers. Some others served under unscrupulous men who indulged in illicit country liquor trade. A few youngsters were allured by the subversive groups that were operating in this areas, with the aim of changing the social system through violence. The languish of the people thus reached a turbulent stage, a near

riotuous situation. The police in the quest of these elements combed the villages, questioned the families and harressed the innocent folks. There was panic, fear of insecurity to life and property among the people and the Centre for Rural Health and Social Education made entry into the scheme to do something for the people, through the process of social change.

The CRHSE is an independent organisation owing no allegience to any political group. It stands uncompromisingly for a healthy and dynamic democracy without which the deprived mass cannot struggle for their legitimate claim of the fruits of development. What prompted the CRHSE to launch the project has been mentioned in an earl er publication by the institution thus. "The process of discovery in togetherness is not motivated by instincts of charity; certainly not fi om the surplus feelings of humanitarianism; but due to historical compulsion. It is an attempt to live up to their responsibility to history".

The project of the CRHSE is a two pronged strategy as the name of the Organisation indicates, namely Rural Health and Social Education. This strategy was envolved by the Centre in the light of a preliminary study conducted in April 1978. The study covered sixty seven villages and one hundred hamlets in the Tirupattur panchayat Unions. The survey was extended to Elagiri and Javadhi hills to cover twenty eight hamlets in seven panchayat villages.

The information relating to social, political, cutlural and health condition was collected from the people through direct discussion rather than the usual questionaire (interview) method. The process of data collection was therefore informal. The questions were grouped under few major heads; social, economic, poiitical and health. A nucleus of field staff along with a Coordinator completed the survey work in a period of six months. Before the information was processed a test check was conducted to ensure reliability.

The finding of the study helped the team of voluntary workers to acquaint itself with the area and the people, to identify their problems and perspectives and to formulate a suitable projects for a solution. The visits to these village and the dialogue with the people earned their endearment and infused confidence in them; that paved the way for the smooth operation of the project later.

Findings of the Survey

Social

The Social groups or castes in the area of operation of the centre conform to the pattern prevalent in rural Tamil Nadu, each caste engaging in a specific occupation. Some of the major castes and their occupation are given below:-

caste	occupation
Vanniars, Agamudiar, Mudaliar, Naidu	Cultivators & Agricultural Labourers
Harijans	Agricultural labourer
Parayer	Drum beaters
Sakkiliar	Cobblers

Navithars	Barbers
Vannars	Dobies
Achari	Carpenter, Blacksmiths
Singhs	Cultivators
Pattala Naioker	Agricultural labourer
Muslims	Traders
Manthiri	Agricultural labourer
Boer	Stone cutters
Kuyavar	Potters
Kuravar	Basket weaver
Chanan	Tree climbers

Hills

Malayalis	Cultivators
(Karalars)	Forest labour
Thombers	Collecting
Irulars	Forest producers

In the villages caste divides the people and prevents intermingling in social or cultural functions. Normally the lands are owned by the vanniars, mudaliars, naidus and marathis, who offer employment to the harijans, who invariably form the agricultural labour force. The former category are considered upper castes and the latter lower castes. The low caste people's continuous functioning as agricultural labour without upward mobility has resulted in seldom in the rural areas. The upper caste people enjoy control over these lower caste people socially and economically. This age old system has been the stumbling block against social unity. As a result, the village could not be developed through common welfare programmes. Religious festivals in temples do not keep unifying the cultural feeling of the people. So, they have seperate temples and rituals. Even drinking water has been provided separately for the upper and lower castes people. This social oppression of the higher castes is not opposed by the lower caste people and therefore economic exploitation remained firm and accepted as unalterable practice.

Economic

The patern of ownership of land is closely linked to the caste hierarchy. As told already the upper caste people owned the lands, the only means of production in the villages. Less than ten percent of land owners possess more than 30 percent of the area cultivated. Some of the land owners live in the urban area leaving the lands to the local residents who are also from the upper castes. In villages like Nadu Pattarai, Pudur, Jaffarabad, Vijilapuram and Madekaddapa more than 70 per cent of the lands is owned by absentee landlords. Nearly 80 percent of the cultivators hold less than five acres and form the small and marginal farmers.

Paddy, Ragi, Maize, Groundnut and Sugarcane are the crops raised in this area. Rich farmers plough the lands with tractors, owned or tired. Ploughing with bullocks is common among the small farmers. As for other agricultural operations, the rich landlord employ permanent labour while others avail casual labour. The permanent workers may be bonded labour

also. The well to do farmers use pump-sets for irrigation, others depend on rain water or lift water from wells, lakes or river with bullock kavalai or manually operated poles. The small farmers adopt traditional methods of cultivation while the rich farmers chose modern methods. The yield through the farmer method is comparatively poor and therefore income from land is less in the case of small farmers.

Agricultural labour is not getting the minimum wage fixed by government. The workers are not aware of the rates fixed by government for different operations; even if they know they cannot agitate for the fair wages, due to lack of organised effort and the social heterogeneity. The study reveals that there is wide variation in the wage rates among the villages. In Chettiappanur, Thuraieri and Pudur of Alangayam panchayat union, male worker gets Rs. 8/- and female worker Rs. 3 per day without food for agricultural work. In other villages the rates ranges from Rs. 3 for male and Rs. 1.50 for female workers to Rs. 5 and Rs. 3 respectively. The disparity in the wage rates shows the imperfect labour market and poor bargaining power. In the tribal areas the wages are paid in kind mostly at the rate of 3 and 4 manams of grain per male without food, 2 to 3 manam per female worker and 2 manam per child worker (manam is a lical measure of foodgrain). In the hills small millets like ragi, samai and mustard are raised as dry crops. Fruits and vegetables are also cultivated usually on a small scale with family labour.

Political

The down trodden people are not aware of their rights. Their duties are mostly governed by custom and religion. They have been taught to respect elders. They don't raise their voice against injustice done to them by elders from their own community or by any other person belonging to the upper caste. Outside their community, the low caste people show regard to the religious heads, school teachers, village officials and rich landlords. For matrimonial alliances, for celebrating a social function or for exercising franchise, decisions are taken by the elders and elites, without seeking a word of consent from the persons involved. The people do not know to whom or to which party he has voted in the last elections and they have on affiliation to any political party.

The tribals, though there is no caste conflict within the community, are aware of the exploitation by outsiders, persons, from the plains. Yet they bear it, as it is an age old practice. Some of them do not find anything wrong with this system as it has become their way of life.

The rural people and the tribals have no knowledge of political administration even about the local panchayat. They feel that it is for the rich and upper caste people to become office bearers of panchayats. They are therefore indifferent to the administration. As for government programmes implemented in their areas,they show no response or enthusiasm. They believe that these programmes do not confer benefit on them. According to them the programmes are intended for the benefit of the rich and higher caste people.

Health

The study has revealed that the people are affected by all common diseases that are found even in educated urban areas, but the frequency of suffering from such ailments and the intensity is more in this area, as the people are living in insanitory environments, without adequate nour-

ishment. Becuase they believe that diseases particularly the chronic disease are caused by the wrath of the Gods, they seek the help of the priest to propitiate the local deities. Approaching the native doctor for cure is also due to the proximity and inexpensiveness. The system of hospitalization for treatment is against their culture. Modern medicine and allopathic treatment have no relevance for the people living under rural and forest settings. That is why they do not depend on health programmes sponsored by government. They don't think that elimentary diseases are caused by drinking contaminated water and therefore do not strive for the provision of drinking water facility. Contamination and pollution of water are not considered health hazards and therefore no attempt to drink purified and boiled water is made.

Project Formulation

The Centre for RH & SE was formally inaugurated in 1978 after registration under Indian Society Act, with like minded social workers willing to serve for the cause of the weaker sections in Tirupattur Taluk of North Arcot District, Tamil Nadu, with the main objective of promoting the welfare of the people through community health and social education. The participatory character of the research study was extended to the formulation and implementation stage of the project. In other words, the approval and participation to the targeted beneficiaries was obtained from the beginning. They were invited to discuss the plan and mode of operation of the project, so as to ensure their involvement. This took nearly six months and the project was launched in February 1979.

Three sub centres were formed initially in Bommikuppam, Nimmiyampattu and Jayapuram zones. Six village clinics were organised at the rate of two per zone. Each village clinic is administered by Village Development Councils (VDC). Two representative from each of the major caste groups in the village are chosen to constitute the VDC: In each of these VDCs not less than five castes were represented. The village officials were purposely excluded from the VDC, as they belonged to the affluent community and exercised social and economic control in village.

The organisation of Village Development Councils (VDCs) is the first step in the operation of the project because of the following advantages: 1. VDC is an organisation of the people represented by all major caste groups. Unlike the panchayats its composition includes the oppressed community, which hither to did not come forward to discuss social problems either because of their customary reverance to higher caste people or of their timidness and indifference.

2. The formation of the VDC has infused confidence in the people about the CRHSE, which easily established report with the village folk, particularly the Harijans, who left to their own would not openly discuss matters, even concerning their welfare.

3. The CRHSE has been able to find out the social and health problems in the village in the course of the VDC meeting and has prompted the people to seek the solution themselves.

4. Because the VDC is planning the welfare measures it is easy to enlist their cooperation, enthusiasm and involvement which are lacking in the implementation of the government sponsored plan schemes.

5. Success or failure of the schems either at the planning stage or at implementation stage could easily be assessed by the people themselves. Bottle neckes or short falls in the progress are brought out so that modification could be made at any level.

6. The weaker sections in the village are able to putforth their views fearlessly to claim their legitimate privileges by debating and eliminate exploitations by questioning. The higher caste groups in the villages have either relented in extending the legitimate benefits to the down-trodden people or abstain from participation in the VDC.

7. The VDC has been the uniting force in the village and exert pressure on the bureaucracy for achieving the gains of the schemes intended for the village. Instead of one individual meeting the government official, the whole community through the VDC makes demand for their common cause.

8. The functioning of VDC representing different caste groups has made the village people forget their differencess realising that the oppressed group has gained strength to be more valiant. The organisation of the VDC has largely helped the CRHSE in pushing their project in the villages. The VDC provided accommodation for the village clinics. It was through the VDC, village level workers (VLW) were selected. The CRHSE could collect adequate information about the people, their way of life, resources, occupation, income, social problems that hamper progress etc. through and from the VDCs. The VDC's are therefore the vital link between the village people and the CRHSE in evolving the strategy for their project and the modality for implementation.

Rural Health Programme

Health and Education are the two essential elements for promoting the development of the individual. The improvement of these two, raise the standard of living and the quality of life of the people by increasing their income through larger productivity. The CRHSE has rightly chosen these two aspects as their main objective, for improving the economic condition of the poor in Tirupattur area.

Rural poverty is reflected in poor nutrition, inadequate shelter and low health standards. These in turn affect the productivity of the rural poor and the quality of life. Therefore the needs are production improvement, and mutually re-inforcing programmes to provide better nutrition, improved water supply basic sanitation and practical education and health programmes.

Recently the union Minister for Health, Mr. Shankaranand deplored that allopathy had let down the poor. "The western system of medicine had by and large failed to recognise the poor man and tackle diseases like malaria, diarrhoea, tuberculosisblindness and leprosy affliting him. It stressed only the curative aspect and was indifferent to the preventive and promotive aspects. It mostly catered to the rich men", he said. The aim of the CRHSE's health programme is to search for a way in which people can live healthly, that is not only to achieve freedom from disease, but also freedom from the threat of disease and in a more positve way to create the conditions and atmosphere which enables them to live in uninterrupted good health.

The health programme of CRHSE is based on the fact that 1. efficient health care should be less expensive if it is built on preventive and early treatment.

2. Simple village folks can be trained to undertake a considerable degree of health in their own communities and

3. improvement of health is possible through health education. For the implementation of the health programme on the above basis, the participation and involvement of the people themselves from the very beginning of the programme are crucial.

Health Education

The rural people are not conscious of their health. They do not feel like guarding them from diseases. Even when they are afflicted by sickness they believe that it is God's punishment and there is no way to escape. They therefore do something to please the Gods rather than approaching medical men. The purpose of health education is to remove such misbelief and to prove ill health is not caused by karma or God's wrath, but due to malnutrition unhealthy environment and lack of knowledge of health. Health education includes building up of awareness among the people that poor health and sickness are directly related to the present socio-economic conditions and that they have to change these conditions in order to promote health.

The health education programme is conducted by the VLWs in their own villages who were already trained in paramedical course. The mobile health unit also imparts health education during its visits to villages. Audio-visual aids and teaching materials have been provided as education media to suit the capacity of understanding of the village folk.

The health education programme is imparted to groups of people by assembling them in the clinics regularly every month, besides the instruction given by the VLWs during their medical dispensation. Another effective medium of health instruction is through drama enacted by the CRHSE staff with impressive dialogues in the language of the local people.

The health education programme is slowly being extended to school children, the vulnerable section prone to disease. Once a month the field health workers conduct health education classes to school children with the consent and support of teachers and parents. These health classes have been helpful in the conduct of health check up of school children who are otherwise apprehensive.

The health education programme normally is held in the evenings when the village people are free after work. They are not dumped and bored with do's and don'ts of health hygiene and sanitation. How the people are afflicted with sickness, the causes of diseases, preventive methods and curative processes are communicated to them in simple language with humorous stories, and exciting anecdotes. When it becomes dark slide shows follow to reinforce what has been already covered by speech, and through visual medium. The idea is to make the village community respond to these folk songs and subsequently developed their own audiovisual apparatus. One thing is quite perceptible as the after month of health education; that is, the people have become more health conscious and seek medical help from the village health workers in large numbers than earlier at the commencement of the programme as proved by the record of patient attended in the clinics.

Health Care Programme

If health education is preventive measure of the comprehensive rural health programme, the complementary part, namely the curative aspect is attended by the running of health clinics where patients visit for treatment. As mentioned already, the study finding revealed the type of common diseases prevalent in the areas. The VLW has been provided with medical kit containing medicines for such diseases that could be treated in the village clinics.

The village clinic are housed in the panchayat buildings. The popularity of the village clinic attracted the people from the neighbouring villages. During the first year of operation of the programme, 11,337 patients were treated in as many as 211 adjoining villages. On an average not less than eight patients visited the village clinics daily for treatment.

Besides treating the patients at the village clinics, the mobile health team made visits to each of the six sub-centres once a week. The dentist also visited the sub-centres where dental care was found necessary. The school dental screening was also taken up simultaneously with the general check up by the mobile unit.

The health service scheme covers the following essential aspects: 1. Ante-natal and post-natal care.

2. Under fives care, check ups, immunisation regular follow up and practitioner advice.
3. Leprosy detection and treatment
4. T.B. detection and treatment.
5. V.D. detection and treatment
6. Dental care-oral cancer detection and treatment; preventive dentistry and dental checkups

The CRHSE through their research study and experience with the people of the villages in this area have found the unsuitability of the modern medical system which is illness oriented, personalised and expensive and therefore evolved a distinct programme of health service which is simple, inexpensive and practical for those in need of assistance and service, using the existing facilities adopted to the needs and conditions of the community.

Another interesting feature of the health delivery programme is the introduction of Family book system by the VLWs. A book was maintained for each of the families reporting at the clinics. Nearby 1900 families were covered under this system during the first year of the programme. Details of the illness reported and treated at the clinics in respect of each member of the families are recorded in the family book which served as family, as well as individual case history records. The health programme is thus not confined to individuals in the family but views the problems of health of the whole family which is the unit within the community.

The health education programme and the health care programme are community programmes so that a wholistic approach is aimed at.

Health Personnel

One village level worker has been posted to each of the six key villages. The village level worker is recruited from either a tribal or village community on the basis of nominations of the village development councils. The essential qualification for selection to the VLW post

was the acceptance by the majority members of the village community. The VLW may or may not have the minimum educational qualification but must have the capacity to assimilate the training imparted during a period of 12 months and the aptitude for social service. Each VLW is provided with a drug kit containing medicines and First Aid materials. The drug kit is replenished every month.

At the sub-centre level one trained Health Coordinator is posted to coordinate the work of VLWs within the Subcentre-Health Coordinator is also a trained para medical worker. The guidance, supervision and coordination of the entire health programme are looked after by well qualified, but dedicated, staff stationed at the head office of the CRHSE. These staff also form the mobile health team consisting of one physician, one dentist, one trained staff nurse and one health coordinator.

The trained village level workers at the grass root level play the important role of substituting the trained medical MBBS Doctor. These rustic girls, simple and semi-literates have understood the people more thoroughly and are able to create awareness among their people who readily responded to the call of VLWs. Since the VLWs are all women, they have no difficulty in infusing confidence among the people for whom they serve.

Social Education

The normal school education, the formal education and also the nonformal education are not relevant to socially oppressed people, who have no faith in such education which does not bring in tangible and immediate benefit to them. The downtrodden weaker sections of the community, that forms the majority in rural areas, must be made conscious of their rights in society, which they do not claim because of social inhibitions and not because of illiteracy. The assault on a harijan individual by a member of higher caste is not questioned or the matter not reported to the police, because of the low social status and timidness of the former. Normally disputes between the upper caste groups and lower caste groups are settled within the village by the local panchayats in which the latter has no representative or even if they represent, they are reticent in the midst of elders from the elite group. The harijan and other low caste have been enduring insults for fear of losing employment, or expulsion from the village. The social education should therefore remove the barriers that hinders even the normal life of individuals and their employment.

Soical education cannot be in prefabricated formula that can be applied to all situations. The social problems vary from one region to another, and that education must enable the people to live in peace, enjoying freedom, fairness and honour. There may be villages where people of different castes live amicably. In another village minimum wages prescibed by government are not paid to the agricultural labourers. There may be faction in villages because of the harijans not allowed to take drinking water from the well belonging to the higher caste. The purpose of social education is to make the people aware of their situation, organise them and through small efforts build up the acumen to fight against injustice and oppression. The people learn through social education certain facts, about the society around them, the reasons for their ignorance, poverty, ill health, pattern of production ownership of means of production, source and contribution of labour to production, social oppression and exploitation.

The unique social feature in this country and particularly in Tamil Nadu, is that the harijan or scheduled caste form the agriculatural labour-force. The caste and custom bound people could not be organised as working class for collective bargaining. They can be united on caste basis but not on class basis. Poltical parties have taken advantage of this situation for gaining popularity but not to transfer benefit to the people. These people of harijan community continued to be ignorant of adminaistrative politics and are not able to exert pressure for their well being. Naturally the local affluent community by virtue of their status, wealth, education and influence easily exploit the downtrodden community. At the same time they avoid the benefits of all development programmes sponsored by government, the innocent, ignorant and exploited community remain undeveloped and poor.

Mode of approach to the problem of social education is not rigid and sterotyped. The content of social education syllabus is more flexible to suit the local situations and problems. In order to select the type of education suitable to a particular village situation, the agency interested in the programme must make a study of the social, economic and cultural problems. This study is possible and will be successful if that agency acquaints with the people and through them their problems, and evolve the programme for social education. The CRHSE had already conducted a research study of the villages and familiarised with the issues that are pressing. There was no difficulty in formulating the plan for social education with necessary variations.

Programme Operation

Having gained the confidence and popularity of the villagers through their health programme, the CRHSE, with the help of the Village Development Councils (VDC), began organising groups of landless agricultural labourers and marginal farmers in the six villages. The youths, being the vulnerable and vocal groups of the population, were easily lured by this programme. They assembled themselves into viable units in the villages. Since majority of the landless agricultural labourers and small and marginal farmers belonged to the lower caste groups, the organisation of youth units faced no difficulty.

The youth meetings were conducted frequently, when the Field Workers, from the CRHSE explained to them the need for undertaking detailed analysis of the socio-economic structures in the villages. The members of the youth groups collected information relating to the actual distribution of land, (the only means of production) agricultural wage rates, employment potential, unemployment and under employment. This information was required for traming economic plans for the unemployed and underemployed people. In the course of the collection of data more deeper social issues such as the standard of living among the poorer sections of the society and the corresponding socio-economic institutions of the rural communities were brought to light.

In order to assist the field staff in pushing the social education programme effectively among the village communities, a few contact persons were identified in the selected village the contact persons carried further the follow up action in the same villages and later extended the programme to the neighbouring villages. The CRHSE organised rgular dialogue programme on socio-political issues confronting both the macro and micro level situations. Two to three perons drawn from each zone attened this progamme along with the respective field staff during the week ends. The trained persons would become a support to the work of the field staff and

eventually took over the responsibility of visiting the target people and motivating them to strive for their rigths and making them aware of their legitimate socio-economic and political privileges. On an average thirty participants including the field workers attend the week end dialogue programme. These persons were selected by the field workers from their respective areas. This training enabled the persons to understand the socio-economic problems in their villages and plan solution for the development through process of institutional change.

Techniques and Responses

"The technique adopted was essentially dialogical and eliciting answers through probing questions. The techniques varied from group to group. The issues used to be economic, political and historical. The sessions would commence from the familiar and then move on to the unknown; begin from to difficult and climb up to the complex. For instance, a person belonging to a high caste man handling an untouchable is the familiar and simple issue. This would be the starting point of crushing discussion on social organisation called caste system.

The participants used to respond by coming out spontaneously with their own life situations and substitute what was ignored or bypassed. The opportunity would be used to recall historical events and relate them to the context. The responses of various groups to such events and the why of such responses would be critically analysed.

The sessions used to be stimulated with simple questions drawn from the local life situations, which in turn would lead on the discussion. Quite often, stimulation would be by taking a radical position, "Land reform never solve the land problem".

Some times newspaper cuttings or some hand bills would be taken up as resource materials for reflection and by stages the events or concepts would be linked up within the large scheme of things. These training programmes are designed to develop the sk lls of analysis and organisation". (Yondes the Hills)

Siddha Health Project, Neemur, South Arcot

Siddha system of medicine is a well known traditional herbal medical practice in India, along with the other two system of Ayurveda and Unani. The books of Siddha medical treatment are in Tamil. The obscure verse form of the texts is not understandable to the common man, with the result the practitioners of siddha system of medical treatment are not many. But its efficacy has been proved, especially for treatment of chronic diseases like Cancer, Asthma and Lperosy. Because of its simplicity in administration the village folk confidently depend on the native doctors who practise the siddha system. It is less experience also.

The Tamil Nadu Social Service Association, which had received training and assistance in developing its programme of social education from CRHSE, wanted to popularize this system among the rural people in its area of operation. But pauc ty of funds and infrastructure made their attempt difficult. Fully real sing the significance of this programme and its probabley effectiveness in community efforts, CRHSE in consultation with the officers of TNSSA, assumed full responsibility for the planning and implementation of the programme with experienced personnel and other administrative materials.

Five young women were trained in 1982 in Siddha as VLW in the Siddha dispensary, taken which was later converted into a training centre for VLWs on the advice of CRHSE. The pattern of training was similar to that under CRHSE programme but for the treatment based on siddha system. The VLWs dispensed siddha medicines from their kits to the villages and prepared family cards for 675 families. The Siddha clinic at Neemur attended 4780 patients during 1982.

Another batch of 10 VLWs were selected for training in 1983. The VLWs also function as Social Education Workers to create awareness among the people and motivate them for better life.

Internship/Field Placement

The CRHSE offered rural internship programme informally for those who wish to utilise our experience for field training and practice. Besides class room discussion field placements were arranged for the benefit of the visitors provided their stay was long enough. This service of CRHSE has been extended to various organisations engaged in social service in Tamil Nadu and other states of the country. This offer has been availed even by winters from foregin countries. The period of internship varied from two days to two months according to the nature of their interest.

Communication Programme

In the course of implementing the programmes of rural health and social education, the CRHSE found that cultural approach through folk dance, songs and drama, and better appeal than discussion and dialogue. The centre also identified that some of the staff members and VLWs have this talent. In order to pool the creative talents of these personnel, a communication team has been formed with these persons. This team helped in the training of VLWs in various communication media. The programmes include folk songs, dance like 'Kummi' and Kolattam; Street dramas 'Therukoothu' and musical discourses (Kalakshepam) preparation of programmes in this medium, and presentation before the village folk created interest in them as they were in their own dialogue form, without ostensible stage settings, dresses, make up, lighting arrangements. The CRHSE encouraged and trained the village people coming forward to perform public show. Similarly school children were also encouraged to perform these folk-loves by imparting suitable training. It was also hoped to raise small funds from their own communities for the VLWs to carry on their programmes.

One communication Coordination has been posted exclusively to attend this work.

Having gained experience in this programme of training of village youth cadres for social education, the CRHSE is offering facilities for like minded agencies as part of the preparation for rural internship programmes.

Programme Achievement

The achievement of the programme cannot be assessed quantitatively because it relates to social change, change in the attitude of people health consciousness, awareness of social problems that comfort the weaker sections of the community etc. But the change due to the

implementation of the programme is perceptitble in the villages, where it is in operation. This change could be assessed by interviewing the beneficiaries and the responses compared with that of the people in the adjoining villages. That would become a seperate study involving time, labour and money. However the achievement could be demonstrated by highlighting the performance of VLWs.

The VLWs have been selected at the instance of the local people whose involvement in the programme is ensured.

The VLWs offer their services, voluntarily for social work-a sign of acceptance of the programme. A perusal of the profile of these VLWs reveal the following facts:

a) of the 56 VLWs selected and undergoing training during 1979-1983. 44 were females and the rest males.

b) They were in the age group of 16 to 42. Twelve were below 20, 36 between 20 and 30, 5 between 31 and 40 and three over 40. The majority of them were below 30 years and so energetic, active and alert.

c) Thirty five of the VLWs were married women.

d) As for the educational qualification of VLWs, 35 of them had studied upto secondary school level and had come higher secondary level. Only seven studied upto primary school level. Even though the CRHSE prescribed no educational qualification, except the acceptance by the community they were able to secure the services of VLWs better educational qualification than expected.

e) Six of the VLWs were without any occupation. As many as 31 were engaged in agriculture either in their own land or labourers. Those employed in other occupations included 4 balwadi ayahs, two petty shop owners one beedi worker, one tannery worker, and one balwadi and adult education teacher. Nine VLWs were housewives. The willingness of the VLWs to work for their community wothout remuneration is proof of their acceptance of the programme.

f) There were also some drop outs during the period of training. A few VLWs could not be awarded with medical kit. Only 34 of the 56 VLWs successfully completed the training and proved fit to receive the kit. The reasons for the discontinuance of the training were marriage, family problem, pregnancy and employment. Irregualrity in work, poor grasp, and failure to pass the prescribed examinations had deprived a few VLWs from getting the kit.

The involvement of the villagers in the health programme could be counted upon as our achievement. The services of the VOWs were utilized for the welfare of their own community, while would remain and untapped in the absence of the programme. The spare time of these workers is channelised for the benefit of the community.

As a result of the training, the limit and relicent workers of the villages acquired knowledge about health, hygiene and sanitation and are able to pass that imformation to others convincingly. They meet the people of their respective villages, gather information regarding health problem, provide health education keeping in view their standard of living and surround-

ings. Instead of wasting their time of idle talks at public places like common walls, work sites, and religious conquations, these VLWs engage them by discussing health matters. The talented VLWs not only sing songs relating to prevention of diseases, sanitation, malnutrition etc. but also make the members of the community sing, dance and enact dramas, so as to reinforce the education already provided.

The VLWs take care of the most common illnesses in the villages, as they are available right there in the community. The cost of the medicine is very low to suit the purse of the people. By this interaction of VLWs with their respective communities on matters pertaining to health, social and economic problems, the communities begins to think about their problems and also accept VLWs as promoters of health in their respective villages. Of the total number of patients treated by the CRHSE at different levels, 60 per cent of them were treated by the VLWs. Such is their roll in health programme.

The importance of the presence of VLWs among the community has now been realised and the VLW is able to organise women and youth groups in the villages. The crucial role of the VLWs in health and education programme has benefited some of them in getting selected for dhai training, embroidery training and community health guide training on the recommendation of the CRHSE, so that they can better their prospects. The CRHSE sponsored a few VLWs for special training in community health at Madurai. Some other VLWs secured employment as Adult Education Teacher, and Community Nutrition Ayah through the efforts of CRHSE.

To boost the morale of the VLWs among the public, the medical kit is awarded at a function organised by the community.

Programme Consolidation

Enthused by the easy acceptance of the programme, and encouraged by its achievement, the CRHSE decided to consolidate the gains in the villages already covered, instead of extending to other villages. The demand for the introduction from other villages is pressing, the CRHSE has advised the VLWs to treat the patients from those villages if they come for medical help. The organisation of village Development Councils, Youth Clubs etc. is left to their own efforts without CRHSE's involvement.

The project started with 6 villages in 1979 and now covered 80 villages which is considered the optimum number for intensive work and stability. However managing all the 80 villages from the headquarters at Tirupattur has been found administratively unwidly. It was therefore decided to decentralise the administration by forming Zonal offices at three places; namely, Tirupattur, Jayapuram and Vaniyambadi. Each Zone will be administered by one Zonal Coordinator with one honorary medical consultant assisting him on the health side. The duties and responsibilities of the Zonal Coordinator includes Zonal Administration, staff and programme Coordination, maintenance of medical equipments, training internship community relations etc. The medical consultant will visit clinics regularly, provide clinical support, give advice and take follow up action if necessary and supervise training of VLWs.

Under each zone three sub-zones have been formed as below except in Tirupattur zone.

Tirupattur	Jayapuram	Vaniyambadi
1. Yelagiri hills	1. Jayapuram	1. Nethajinagar
2. Timmanamuthur	2. Puthagaram	2. Vallipattu
	3. Narianeri	3. Sathyanathapuram

Each Sub-zone maintains the village clinic, which caters to 10 villages within it through 10 VLWs. The Sub-zonal Coordinator is responsible for the maintenance of clinics, health education, training and Coordination of VLWs, village visits etc. Each of the ten villages will be filled in a phased manner covering three villages during the first year, another three in the next year and so on. Ultimately by 1986 there will be 80 villages with 80 VLWs, in 8 sub-zones, within three zones.

Besides, the Coordination Team, under the Communication Coordinator will function from Thimmanamuthur. He will organise health education programmes in communities, youth and women's groups, schools etc, provide media programmes, and train the staff, VLWs, interns and others on communication media.

At the headquarters, the Director will deal with Correspondence funding coordination, financial administration, staff coordination, programme coordination etc.

Programme Achievement

Impact of the Programme

The CRHSE is certain that in the work of uplifting the rural poor and organising them, it is the people who should plan and decide. The voluntary agency has played the role of a catalyst. Even while making the preliminary study of the villages, the people were involved. The collection of information was through dialogue, therefore the materials gathered was qualitative rather than numerical. After collecting the data, and analysing the facts, the findings were placed before one people for discussion and then the programme was evolved. The CRHSE sent support to the execution of the programme by conducting training to the VLWs and youth cadres. The selection of trainers was on the basis of nominations from the VDCs which are also people's organisation to frame and implement the programmes. Rightly speaking it is not the peoples participation in the project, but it is their involvement, both in planning and exceution, while the CRHSE only ignited and stimulated the latent desire for development. The workers of the CRHSE exposed the social institutions that prevented development and the people then made efforts to change the social structure. The people are informed that drinking water was a problem for the harijan, because of the social evil of casteism; once casteism is removed, untouchability vanishes and consequently the drinking water well becomes common to all. The CRHSE pin points to the ignornant people where the shoe pinches and removing the thorn is the task of the sufferer.

PART II

An Evaluation Report

F. Stephen

Daisy Dharmaraj

PREAMBLE TO THE REPORT

The basic premises of the evaluation:

This evaluation has been carried out on the basis of a set of premises reflecting certain value system related to evaluation of development projects. The premises are as follows:

1. The actual work carried out by a group of people in the context of socio, economic, political and cultural realities spread over a long period of time, just cannot be 'evaluated' by a "Team of evaluators", however competent the evaluators may be, by merely spending a week or 10 days at the project area.

2. Even though the impact of the programme may have far reaching social and political implications, nevertheless it is difficult to establish cause-effect relationships, for ocial change is a complex phenomenon.

3. Evaluation is a continous process and the 'outcome' of the evaluation cannot be dissociated from the 'process' of the evaluation. Therefore, if the 'outcome' is viewed independently, not related to the process itself, then it may not be a fruitful exercise.

4. Evaluation is effective and useful only when the people concerned themselves carryout this exercise against a set of 'objective criteria' and the exercise is preferably facilitated by an 'outsider' in whom the project staff have confidence.

5. Evaluation is a process which benefits the evaluators as much as it is helpful to the project people.

6. Evaluation should be 'delinked' from 'Funding' to widen it's scope and to eliminate a sense of 'fear psychosis' usually associated with 'evaluations'.

7. Evaluators should clearly state their 'Role' in this exercise at the very beginning, to overcome role ambiguity . For eg. it will be helpful if the evaluators, through their spoken words and actions, communicate that they are performing a 'facilitative' role rather than an 'investigative' role.

8. Evaluation should have a "participatory model" if it were to be productive, not only at the 'Chief Functionary' level but down to the'core staff, of the organisation.

9. Evaluators should share at the very beginning the 'methodology' and the 'tools' to be used for the evaluation and the project staff should be convinced about the objectivity of the 'tools' and should be inclined to use those tools.

10. Lastly and most importantly at the very outset the objectives of the evaluation should be clearly spelt out.

Objectives of the Evaluation:

The objectives should be to strengthen the 'programme' and the 'project', thereby benefiting the 'people' to whom we are *committed* and *whose needs* the 'programme' and the 'project' strives to serve.

CHAPTER I

Prelude to the Evaluation

The evaluation team consisted of two people, Dr. Daisy Dharmaraj, Director of PREPARE and Mr. F. Stephen, Director of SEARCH, with the latter having the additional responsibility of coordinating the entire evaluation besides writing the evaluation report.

It should also be mentioned here that it was the unanimous decision of the CRHSE staff team to request Mr. Stephen to serve in the evaluation team and both, Christian Aid and Bread for the World, the two funding partners of CRHSE, willingly agreed to request Mr. Stephen to coordinate the evaluation. When the funding partners suggested that Dr. Daisy be the other member of the evaluation team CRHSE willingly accepted this proposition.

The salient feature here is that the evaluation team members were the '*consensus*' candidates of CRHSE's Managing Council, staff and Chief Executive – as well as the funding partners.

Preliminary Meeting:

After the intial dialogue between the project holder and the funding partners, in arriving at the 'terms of reference' for the evaluation and after identifying the 'evaluators', a meeting was arranged between the funding agency representative, evaluators and the project holder, at Bangalore. This preliminary meeting was held on Tuesday, 21st January 1986, to discuss the 'terms of reference' and scope of the evaluation, probable dates for the evaluation, methods to be used in the evaluation and other logistics of the evaluation. During this discussion it was agreed to hold the evaluation between 23rd and 31st of March taking into account the convenience of project holder and his team as well as the availability of the evaluators.

The Evaluation Begins:

As per the agreement, the evaluation team members arrived at CRHSE on 23rd March 1986. Soon after the arrival the evaluation team members spent about 6 hours listening to the project holder during which the project holder explained the programmes of CRHSE. A lot of information and literature had been provided to the members of the evaluation team, prior to the visit to CRHSE; never the less this opportunity provided a very clear understanding of the project through it's historical and evolutionary stages. After a detailed disucssion with the project holder and the Zonal Coordinators, it was agreed that the evaluation team would focus primarily on the mainline programmes of CRHSE, i.e Health and Social Education Programmes. It was agree that the team would cover all the three major zones – Tirupattur, Vaniyambadi and Jayapuram – and the Netajinagar Special Programme.

Special Reference to Siddha Programme:

With regard to yet another important component of the programme, namely Siddha it was agreed among the evaluators that Siddha as a discipline of medicine, is as old as Tamil history which is several centuries old. This has been scientifically acknowledged even by the Government of Tamilnadu and there are Government Institutions patronising this school of medicine. However, partly due to the fact that this system of medicine was being secretly guarded, and partly due to the super imposition of western medical system, Siddha has not been popularly promoted.

Therefore, it was strongly felt by the evaluators that it would be unwise on anyone's part to evaluate the concept of Siddha as a form of medicine. On the other hand with regard to assessing the impact of the Siddha programme as implemented by CRHSE, it was unanimously felt by the eveluators that neither of them was competent to do this job nor did they have any knowledge about this branch of medicine. Never the less the evaluators agreed to visit this programme for the following reasons:

Siddha programme has been very much a part of CRHSE programmes, and it was felt that the visit to Nemur would provide the evaluators a background to the entirety of CRHSE. It is acknowledged that it is on account of the sheer dedication and commitment shown by Dr. Christian that the Siddha programme is being implemented. Therefore, in order to aviod any misunderstanding and to provide moral encouragement, the evaluation team agreed to visit the Siddha programme, though certainly not with an intention of evaluating the programme.

CHAPTER II

METHODOLOGY

Use of Sampling Design:

It was agreed between the members of the evaluation team and the project staff that the main focus of evaluation would be on the three zones. It was also agreed that the evaluation team members would visit each of the zones and villages covered under CRHSE programmes.

Under each zone there are three Sub zones and each Sub zone covers 10 villages. To identify areas of visit, it was agreed to use stratified simple random sampling method. As part of this sampling method, by applying lottery method, one Sub zone in each zone was selected and again from the selected Sub zone, through lottery method, two village level workers were selected. To maintain a balance between non autonomous VLWs and autonomous VLWs in addition to the samples selected further samples were selected from among the remaining lot.

Thus this sampling technique provided us objective indicators for the selection of villages and VLWs to be visited and interviewed for the purpose of evaluation. However it should be emphasised that the sampling technique only helped the evaluators to choose the minimum of VLWs to be interviewed. Wherever time and other factors allowed, the evaluators sometimes even covered the entire universe and interviewed all the VLWs in some Sub zones. As it happpened the evaluators were able to cover all the Sub zones in all the three zones.

Respondents:

The methodology adopted was as follows:

To begin with the team of evaluators visited the villages selected under the sample, interviewed the VLWs, and secondly at random, visited the community members and carried out extensive interviews. Thirdly, they visited the Sub zones interviewed the Sub zonal Coordinators and interviewed the patients at random besides going through the medical records and registers.

In addition, whatever it was possible, the members of he evaluation team held meetings with the sangam members and youth associations. However, it should be stated that no strict sampling technique was used in arriving at the respondents from the community. It was partly due to the fact that most of the community members were away in the fields and secondly on account of time constraints. It should be stated here that the evaluators took note of Harijan colonies who are physically segregated away from the caste community. Therefore, Harijan colonies were treated as a separate unit for the purpose of visit and interviews.

Interview Guide

During the course of the interview the evaluators evolved tentative interview guides for the different categories of respondents.

Interview guide used for the VLWs

The focus of the interview while interviewing VLWs was primarily on:

- testing the medical knowledge of the VLWs with specific reference to the diseases they are supposed to treat in terms of the symptoms of those diseases, treatment pattern and their knowledge regarding the medicines they are supposed to deal with
- testing as to how the VLWs relate the causative factors of diseases to the preventive aspects and what steps they normally advocate in terms of health education, in order to eradicate health hazards
- the role of VLWs in the context of the social education programme of CRHSE
- assessing from the VLW as to how he/she performs her role as a VLW, and the motivating factors that enable them to continue their work
- the VLWs perspective of CRHSE's three tier model of the health programme
- the image of VLWs and their acceptance as para medical workers in their respective villages
- lastly, our focus was on ascertaining the VLWs' views regarding the 'Autonomous Model, advocated by CRHSE.

Interview guide used to elicit information from community members

The questions addressed to the members of village communities were related to the

- the sources of medical help available to the communities and which source they used frequently and why
- to find out the community members' view with regard to the role played by the VLWs in their respective villages
- to find out the community members' perception of the functioning of the Sub zone Centre of CRHSE
- assessing the role played by Subzonal Centres with regard to preventive measures and health education
- the functioning of the sangam in their villages, if any, and the role played by the VLW in these
- lastly, through interviews the views of the community about the usefulness of this models of health delivery was also ascertained.

Interview Guide used for Subzonal Coordinators

The discussion with the Subzonal Coordinators primarily was:

- to assess their medical knowledge
- to assess their perspective of VLWs
- to assess their role in training the VLWs
- to study the treatment patterns
- to assess their role 'perspective' of the training of VLWs
- to find out Sub zonal Coordinators' perspective of the training of VLWs
- to assess how they relate to the total goals of the organisation
- to assess their perception of VLWs as a component of three tier system

Data gathered from Primary and Secondary Sources

The evaluators visits also included interaction with the members of Mahila Mandals, Youth Clubs and other associations. As part of the evaluation, members of the evaluation team visited all the Subzone centres, which are also Subzone clinics. The team also visited the central administrative office and went through family registers and other records maintained by Subzone Coordinators, Coordinators and other administrative staff.

Observation as a Tool

The methodology also incorporated observation on the part of the members of the evaluation team with reference to the villages visited, the interaction between the staff and the people and the interaction between staff members themselves.

Procedure followed during the Evaluation

Though a structured form of interview schedule was not used, a semi-structured interview guide was adopted. On an average about 45 – 60 minutes was spent with each VLW interviewed, roughly about 15 minutes was spent with each community member interviewed and about 2 to 3 hours with each Subzonal Coordinators . At the close of the visit to each zone a summing up meeting was held with Zonal Coordinator along with all the Sub zonal Coordinators, lasting for 3 to 4 hours.

This process was repeated in each of the zones and finally on the evening of the concluding day, all the Zonal Coordinators along with the project holder – which is the total CRHSE staff team – spent about 3 hours, during which members of the evaluation team shared their observations, sought clarifications and initiated discussions, some of which extended beyond the frame of reference of the evaluation.

This chapter has clearly shown, the premises on which this evaluation has been carried out, the methodology used including the sampling designs, interview guides and other tools used as part of the evaluation process, and lastly the procedures followed in carrying out this evaluation.

Nature and classificatoin of Assessment

The observations of the evaluation can be classified under different categories:

Firstly, the data gathered during the process of evaluation through observations and interviews have been analysed, interpreted and synthesised in the form of two types of findings namely Broad Findings and Specific Findings.

Secondly, on the basis of these broad findings, certain suggestions are put forth by the evaluators.

Thirdly, on the basis of the findings, certain hypotheses have been formulated which need to be tested and accordingly appropriate measures need to be formulated by the project staff.

Fourthly, the evaluators have left it open for the project staff to formulate their own hypotheses, based on certain sets of findings, interpretations and correlations made by the evaluators.

Fifthly, the report also puts forth certain tentative conclusions.

To sum up

Therefore, it should be observed here, referring back to the basic prem ises of this evaluation, that the report, with regard to certain concepts, very clearly brings out the strengths and weaknesses of organisation; yet it mostly provides an insight into the organisation, raises ques tions and often refers to broad areas wherein the project staff can critically review their programme and evolve an ongoing and continuous process of evaluation.

CHAPTER III

HEALTH

INTRODUCTION

CRHSE health programmes has three important components, namely Health Education Programme, Building of Health Cadre and offering Health Service Scheme. In this chapter, we will deal with each of the components in the above mentioned order, review the programme, describe how the component has been operationalised into specific programmes and formulate inferences basded on the interviews and observations. We will conclude each of the components by assessing the programme against the original objectives. In the last section on this chapter we will review in totality, all the three components of the Health Programme as an organic unit, provide a critique, highlight the accomplishments and formulate inferences and hypotheses relating to the implications of the health programme on the social system as a whole.

I. Selection of Area

The primary area of work in the 3 zones is based on objective data and factors. All the three zones are separated from the main town and are widely spread into the interior areas. As they do not fall on trunk roads, many of the villages are inaccessible and are predominantly in locations where no government programmes are likely to start.

With specific reference to Vaniyambadi Zone, the villages are interior from the town of Vaniyambadi by about 16 kms, in a ghat section, with very little scope of town life expanding even in the next 3 to 5 decades. Likewise, the Jayapuram Zone is away from Tirupattur town by about 10 kms, and the villages are scattered away from the town. The Timmanamuthur Sub zone in Tirupathur zone is perhaps closest, by being about 8 kms away from the Tirupathur town, Yelagiri Hills Sub one also has absolutely no health facilities for about 7 tribal hamlets other than one Sub centre of a Government P.H.C.

II. Criteria for Expansion

What si very encouraging, is that the principle followed by CRHSE, in relation to expansion of the zones,is based on the criteria of selecting villages in each Sub zone around the villages being covered, which would provide scope for developing a nucleus of thus of yet another Sub zone covering villages within a radius, but extending outwardly from the existing Sub zone. In other words, the extension of each zone, is expansion by concentric circles covering, a nucleii of villages in all directions. This provides wide scope for expansion the expansion being consistently away from the town, till the expansion reaches a point wherein it merges with another town.

III. Scope and need for the Programme

In this process, if we take into account the sociological phenomenon of emergence of commercial centres and facilities like health delivery, being often based at such commercial

centres, this scheme would cover the area between commercial centres and the interior areas of villages, where at present no public health services are available. Barring one Subcentre of a PHC at Yelagiri, and another PHC building yet to be opened in Jayapuram area, there is no other facility from the government side. Therefore, the selection of the area in each of the zones has been well planned, the expansion is well conceived and eventually CRHSE would be able to consolidate it's work very well.

IV. Critique

However, it was noticed that the inclusion of Sathyanathapuram under the Vaniyambadi Zone was not entirely due to the above said objective criteria. It was observed that CRHSE began its work in this area to support one pastor who intended to do some work in that area. Subsequently, this initial support more or less pulled CRHSE to take up this area. Certain failures at this Subzone and certain problems prevailing in these areas can be attributed to not following CRHSE's selection criteria while slelecting this Subzone.

Health Education Programme

Introduction

Though for operational reasons distinctions are made, in reality, it is almost impossible to draw watertight compartments between the three components of the Health Programme. Further there will be inevitable overlapping between these three components. Under this section, we would focus exclusive attention on the aspects of the Health Education Programme.

THE HEALTH EDUCATION PROGRAMME INCLUDES THE FOLLOWING ACTIVITIES

A. Immunisation programme

B. Community Health Screening

C. School Health Programme

D. Health education programme through micro communication media eg. puppetry etc.

E. Use of slide shows and audio visuals related to education particularly with reference to TB, Leprsoy etc.

F. Organisation of preventive measures through community action during the epidemics like cholera etc.

G. Organisation of health exhibitions

In this part, we shall briefly touch on each of these activities.

A. Immunisation Programme

With specific reference to the impact of immunisation programme, certain amount of success has been accomplished as indicated by the percentage of the community members who

have immunised their children. This is particularly with reference to Tirupathur and Vaniyambadi zones.

It is interesting to take cognizance of this fact, specially in the context of Indian villages with the tremendous resistance people have towards immunisation due to century old beliefs and traditions.

Viewing it against this background, it can be inferred, that the success of immunisation programme can be correlated to the attitudinal changes which can be attributed to the impact of Health Educational Programmes in these areas.

However, one could locate differences between the zones in this respect, as due to stronger resistance to immunisation, CRHSE is yet to have a breakthrough in implementing the immunisation programme in the Jayapuram Zone.

B. Community Health Screening

In fairness, it should be acknowledged that the evaluation team did not have the time required to review this aspect of the programme and therefore, it will be improper to make any observations this regard. It is suffice to mention, that CRHSE carries out Community Health Screening Programmes, whereby, in a particular village, on a given date, the members of CRHSE health team conduct medical examinations related to dental health, skin checkups, general checkups and other related examinations.

C. School Health Programme

School Health Programme also falls under the category of preventive health and health education. Here again, it will be unfair to make any serious observations as the evaluators did not adequately reveiw the programme. However, the following observations can be made in this regard.

i) The idea of linking parents' associations and the teachers to the School Health Programme is commendable

ii) The concept of involving teachers to play an active role in health education in the schools is again a novel and commendable idea

iii) Yet, anohter significant aspect of the preventive health programme is the concept of educating teenage school children in health education. It is a very imaginative idea, to have taken cognizance of the fact, that in most of the landless agricultural families, it is these teenage children who substitute the parents' role in looking after the younger siblings at home. Therefore, providing health education to this category of children would certainly ameliorate the health condition of the under-fives. This novel programme is presently being implemented only at Tirupathur zone. The programme requires additional inputs and should be replicated at other zones too.

iv) It is observed that the follow-up measures of School Health Programmes need to be strengthened

v) It is generally observed that the impact of school health programme as a whole can only be rated as moderate.

D. Communication programme as a tool for Health Education

The concept of having a communication team in a programme of this kind is a commendable idea. It is also equally significant to recognise the use of folk cultural media in the local language. The communication programme has been playing a significant role in linking the two major components of CRHSE, namely social education and health. It is also identified that the communication programmes have strengthened the preventive aspects of health education programme and have correspondingly enhanced the status of VLWs in their local communities. However, under the zonalisation process, though technically the Communication Team has been attached to the Central Office, the demands put on the central communication team from the various zones could not be effectively met. On the other hand, there has already been a tentative move to decentralise the Communication Team and develop a communication team for each of the zones. *In this context we have the following suggestions to offer:*

i) It is of foremost importance to recognise the significance of communication media in the context of a programme like CRHSE

ii) It is of paramount importance to extensively link the communication programme with the social education programme

iii) It is observed that the present members of the communication team have had very little training in the area of low cost grass root communication media. Therefore, it is recommended that the members of the communication team should undergo intensive and extensive training on the use of different communication methods.

iv) It is also recommended that each zone should have an independent communication team consisting of members from VLWs and Sub-zonal Coordinators of all the three Subzones. This team could initiate frequent programmes in the villages covered by CRHSE, to keep the issues of social education and preventive health alive.

v) These community cultural programmes should involve local people as participants of the programmes and the focus should be, by and large, on the VLW, or on latest issue that are being taken up by the youth sangams or womens groups.

To sum up, it can be very clearly stated that the communication programmes have played a vital and significant role in the health education programme. Although CRHSE has already implemented and is carrying out some of the aspects that are found in the recommendations and we do acknowledge the same. Never the less our recommendations to CRHSE would be to provide further scope and significance to this programme and strengthen it further as this could be the 'nerve centre' of health education and social education programmes.

E. Use of Audio Visuals

Slide Shows

Slide show programme is yet another feature under the Health Educational Programme. The slide show programme is iconducted by the CRHSE staff in the areas covered by their programme, with aid of slide projectors. CRHSE has in its possession, 15 sets of slides, related to various themes, related to health. For eg. a set of slides depicting scabies-depicts, identification of the disease, sources of contact, treatment pattern and preventive measures to be taken to totally eradicate the disease.

It is reported that CRHSE conducts such slide shows once a month in each zone. Roughly anywhere between 50 and 150 people attend each of the shows.

It can easily be surmised, judging from the attendance factor and analysing the nature of health related sets of slides held by CRHSE, that it would certainly supplement the Health Education Programme. Use of audio-visuals certainly has its advantages.

Since the slides have been prepared at professional institutional by experts in the field, it can be safely assumed that health education message will be communicated loud and clear.

Suggestion

It is observed that CRHSE has not used, or perhaps does not frequently use 16 mm films projectors which certainly has an edge over the slide projector in terms of impact.

Secondly, it is noticed that CRHSE does not make use of 16 mm films that are available with government departments related to child and mother care, pre and post natal care, programmes related to nutrition, leprosy etc. It is suggested that CRHSE could reflect on these suggestions and could make use of 16 mm projector and documentary films related to health, from the government, and other sources, in addition to their own slide shows.

F. Health Exhibitions

Health exhibitions are yet another medium through which CRHSE carries out its Health Education Programme. So far, CRHSE has held three such exhibitions at Vaniyambadi zone and one each at Tirupathur and Jayapuram zones. Barring the first exhibition, which was held for two days, the remaining exhibitions were held for one day each. The attendance at these exhibitions ranged from 500 to 2500 people. The content of these exhibitions covered aspects related to diseases, preventive measures to improve health standards, social evils and aspects of social education. However, the prominence of the content in these exhibitions was on health education.

One very significant aspect of these exhibitions is that they were conducted by the local youth clubs or sangams who took the primary responsibility in organising and conducting these exhibitions in their respective areas. It is a logical inference, that these health exhibitions, would definitely reinforce other forms of Health Education, that are being carried out byCRHSE.

Suggestions

By way of suggestions, it may be observed, that taking into account, the vastness of areas covered and not withstanding the fact that 90 villages are being covered, it is conspicuous that the number of exhibitions has not been proportionate to the magnitude of the programme. It may be suggested, that CRHSE could consider this aspect and take appropriate decisions in this regard.

G. Preventive measures taken during epidemics:

Perhaps, the most significant preventive measure taken under the aegis of CRHSE, is its role during the epidemics. Considering the vastness of this country and knowing the efficiency of the government departments, one need not elaborate on the predicaments, chaos and irrevocable damages that occur during such epidemics.

The preventive programmes carried out by CRHSE, particularly when cholera broke out in the areas covered under CRHSE, were remarkable. CRHSE's specific contribution in this regard was, in persuading people, carrying out mass innoculation programmes, and chlorinating the water sources thereby effectively countering the spread of the epidemic in nearby areas.

Reviewing the programme against the objectives:

To quote from the project proposal, as described in the booklet "Yonder the Hills", page No· 3 under the heading 'Basic concepts of the health programme', para 3 clearly defines the objectives of the Health Programme related to Health Education.

> We reproduce below for reference:
> "Oue of the most important means of improving the status of health of the people is through education, since, change in attitudes of the people, is in the long run, more effective than technology alone"

If one reviews the health education programme with reference to the above mentioned objective, it is observed that one coud go to the extent of seeing how far this concept has been translated into operational programmes.

With specific reference to this point, the preceding pages on Health Education indicates beyond doubt that the operationalisation of this concept in terms of programmes has been TOTAL and COMPLETE.

On the one hand, if we were to assess the accomplishment of this objective in the form of the extent and degree of attitudinal changes among the beneficiaries, then the evaluators were handicapped, for pre-programme data, related to the beneficiaries' attitudes referred here, is not available. Therefore, any assessment with regard to this objective will be subjective and we refrain from making observations.

Suggestion

On the other hand, we have been repeatedly saying that evaluation is a continuous process and if that is so, then, it is very relevant to make an observation at this juncture, that CRHSE could formulate measurable indicators and parametres, further data could be gathered and the

correlation of the same would prove in objective terms, the extent of qualitative impact of the programme, as formulated and envisaged to be accomplished by the project.

Building of Health Cadres

Introduction

The second component of the health programme is to Build Health Cadres from the community who would be barefoot doctors in their respective villages. In this part, we will assess this component beginning from, how the VLWs are selected, how they are trained, how they perform and go on to the extent to which they, as barefoot doctors, have been accepted by the village community.

A. Selection Criteria of VLWs

It was observed that CRHSE has evolved a very good set of selection criteria for VLWs. This has been indicated by the performance of the existing VLWs. According to the present criteria, the Sub zonal Coordinator identifies probable candidates and builds up rapport with the candidates or alternatively, members from the community volunteer to become VLWs and some times some members of the community recommend a candidate. The candidates are also provided with adequate information to avoid any misunderstanding at a later stage.

Presently, the Sub zonal Coordinator also takes into account a number of variables relating to social, political, economic and other factors before selecting a candidate.

Out of a total of 100 candidates who have been selected to undergo the VLW training, from the inception of CRHSE, as on December 1985, about 32 candidates dropped out before completing the VLW training.

Considering the rigorous training, which is spread over ten months, and taking into account various factors, this drop out rate is definitely marginal. Out of the 68 people who have received the drug kits, about 13 people have dropped out, whereas 55 VLWs are still continuing. The drop out rate here is 19%. Here again, one could consider the dropout rate to the low. However, one could review the present criteria of selection to reduce this drop out rate for the overall drop out rate is about 45%.

Suggestions

We would suggest that over a period of time CRHSE could conduct a followup study to strengthen their selection criteria for VLWs. Presently, CRHSE has both male and female VLWs and young and middle aged VLWs. If these categories were to be correlated with 'turnover' would provide a very good indicator in arriving at a firm criteria for VLW selection.

If female VLWs were found to be more effective in playing a crucial role in areas like preventive aspects, immunisation, treating more women and children patienets, and showing a higher probability of sustained interest in performance, then obviously female VLWs would be better choice.

Secondly, two categories of VLWs were indetified, those who fall under the youth or adult age group or, for our purpose, 'pre middle aged' group and those who fall under the 'post middle aged' group. It can be checked by correlating the drop out rate among the VLWs with reference to the aforesaid two categoires. If there has been a higher drop out rate among pre middle aged group due to marriage, family circumstances etc. then obviously the post middle aged group VLWs can become an ideal choice.

Similarly one can compare the turnover between male and female VLWs, and this would prove as to which category is more stable. CRHSE should wait and see what the trend indicates particularly, in the light of the fact VLWs trained in 1985-86 are increasingly pre middle aged male VLWs. Their performance needs to be studied and appropriate decisions need to be taken.

It is interesting to observe that VLWs chosen between 1979 to 1983 were predominantly female VLWs and this category recorded a very low drop out rate.

It seems perhpas justificably so, that due to circumstances, the choice is not increasingly on youth male VLWs, and the next five years would reveal the drop out rate of this category.

B. Selection Process of VLWs

There is still room for streamlining the selection process of VLWs in order to make the programme more participatory and effective. Presently, a VLW is invariably identified by the CRHSE staff and then referred to the community for their approval or vice versa.

Since village communities by and large are not organised, cohesive units, when the approval is sought from the community, unless there is reason for voicing any serious opposition, the communities do not oppose the choice of the VLWs. This should be further interpreted, as evidence gathered during the field visits indicates that the village communities do not play any active role in selecting the VLWs. In other words the present process of selection, does not seek full involvement of the community in either the decision of having a VLW or in the selection of a VLW.

However, it should be noted that CRHSE does organise a community function at the time of providing the drug-kit to the VLW after the VLW has successfully completed the training. This is done primarily to make it common knowledge among the villagers, that a paritcular person has acquired the VLW training and is in possession of a drug-kit, and to inform members that they can avail of this facility in future.

Interestingly, it was suggested, even by some community members that if the community can be involved right at the beginning, then there is greater scope for the involvement of the community. In the light of the aforesaid observation, the following suggestions could be considered by CRHSE.

Suggestions

It would be essential to view the role of the VLW in a total perspective rather than considering him/her to be a mere paramedical worker dispensing medicines. In fact, it is antici-

pated that the VLWcould play a crucial role in the preventive health aspects covering the entire community, beisdes initiating social action through formation of youth groups, womens groups, etc.

Therefore, it is suggested that if CRHSE can begin social education programme in the selected villages and proceed onto forming associations and sangams and then leave responsibility with the village associations, to select the VLW, it is assumed that there will be greater involvement from the community.

To cite an example, in a very similar programme conducted by a project in Andhra the following model is adopted:

Firstly, they form the village associations and sangams.

Secondly, the choice is left with the sangam whether they would like to have a VLW in their village – this is after giving full particulars of the programme.

Thirdly, the sangam is given the task to unanimously select a candidate for the VLW and the programme is not started until the village community through its sangam is able to arrive at a consensus condidate for the VLW. As a result, this becomes binding on the part of the community to fully make use of the programme.

However, we are fully aware that such comparisons are improper and the only reason for citing the above example was to explore the possibilities of reaching greater participation on the part of community members in the programme.

C. The Village Level Workers

The extensive and indepth interviews that we had with the VLWs clearly indicated that the VLWs' knowledge reagrding the diseases they are supposed to treat and their familiarity with the treatment process is *extremely good.*

However, we found slight variation in this respect in each of the zones. In Jayapuram and Tiriupathur zones we found that the VLWs' knowledge regarding diseases and treatment processes is very good. On the other hand, we could rate the VLWs from Vaniyambadi zone as only being average.

High Motivation level of VLWs

One aspect that stands distinctly apart is the fact that almost all the VLWs showed a very high degree of motivation, commitment to the task and a desire to work for the improvement of their village community.

Remuneration for their work was not an issue at all, despite the fact that they all come from extremely poor economic backgrounds. It is also interesting to note, that many VLWs have gained social status in their village communities, while some, though they do play an effective role as VLWs, do not enjoy the same degree of popularity. In the majority of the cases, the VLWs have been acknowledged as 'doctors' in their villages. It is true that in alomst all the villages where there are VLWs, for any emergency the villagers approach the VLWs.

However, this should not lead us to heasty generalisation, that the VLW treats all the health problems in the villages. On the other hand, it could be safely stated that, by and large, most of the cases that come to the VLW are for minor ailments like cuts, wounds, fever, cold, cough, diarohea,malaria, etc.

Critique

It was however observed, that the VLWs perform their role mostly on curative side and lack awareness on the preventive side. Further, it was observed that the VLWs do not critically look at the health issues in a social education perspective. This would be an important area to critically review the programme and to appropriately formulate a strategy in this respect.

D. Sub-zonal Centres

With reference to Sub zonal Centres we found that these centres are providing very valuable service as the records indicate that each Sub zone covers, on an average, anywhere between 10 to 25 patients a day. We also found that the Sub zonal Coordinators have very good medical knowledge and are very competent people. It was encouraging to note that almost all the Sub zonal Coordinators are extremely committed and very eifficient staff.

E. Medical Consultants

With reference to medical consultants, it is found very interesting to observe that, more or less, the Sub zone centre can provide most of the medical services without seeking any clinical assistance from the medical consultants. Yet there can still be cases who would need examination on the part of a qualified medical practitioner or confirmation of diagnosis by a medical consultant. Functioning under a qualified medical practitioner also provides certain amount of risk guarentee from a legal point of view. However, under the circumstances, reflection is needed on the appropriateness of utilising the services of full time private practitioners as part time consultants in an alternative health delivery system, without casting any apprehensions about their dedication, integrity and commitment.

The question hence, is whether CRHSE can explore other options. The following points may be considered in this regard:

i) Though the Sub zonal Centres need medical consultants, they need consultants who play more of a professional role to update the knowledge and skill of the Subzonal Coordinators, rather than, someone who directly plays a clinical role

ii) Private practiotioners, being private practitioners, inevitably do develop certain treatment patterns, and while these patterns are needed basically for the survival of a private practitioner, they are often, if not always, harmful to the interests of the patients, nevertheless they are required for their practice. The question now is posed, whether unconsciously, these patterns will be introduced even at the Sub zonal if the private practitioners were to play a medical consultant's role. We cite here examples of cases, wherein antibiotics were administered for simple intestinal/disorders,/and respiratory which no community health practitioner would recommend.

iii) Lastly, and most importantly, the question is raised, regarding how wise it would be to link a private practitioner to a centre of this kind, which certainly will popularise the private practitioner among the ordinary people. This is particularly significant, since the private practitioner continues his private practice in the same town and it is a simple equation of professional interest versus altruistic motives. While we are not providing data to prove that this has happened, we are only cautioning that if such a development occurs in the future, it would not be under anyone's control.

iv) It is also observed that the role preformed by VLWs and Sub zone Coordinators, to a large extent, has minimised the role at the apex level, of the medical consultant, in the three tier system. All the statistical data available in the zone, clearly indicates that there is a steady decline in the cases treated by consultants, and there is a corresponding increase in the cases treated by both Sub zonal Coordinators and the VLWs. It would be even appropriate to state that the three tier system, in practice, has almost become a 2 tier system.

Therefore in the light of the observations made, with reference to the medical consultants, the above mentioned factors should be taken into account and appropriate policy revision will be required in this regard.

F. VLW Training

Though we did not assess the VLW training, either in its operational form, or through other indicators, we used the parameters of the VLWs knowledge level and their performance in the field, to assess the impact of the VLW training. In addition, we examined the content of the VLW training while interviewing the Sub zonal Coordinators who played the trainer role in training of VLWs.

Assessment

The interviews conducted were technical in nature and in depth. The fear of being examined by professional outsiders could have caused anxiety. However, despite the stress, it was indicated beyond any doubt, that *the impact of the VLW training has been extensive and remarkable.*

Suggestions

We offer the following suggetions in this regard:

i) The VLW training has been carried out by Sub zonal Coordinators, most of whom have had their Health training either as ANMs or Community Health Guides and they are competent in clinical work. It is premised that their Health training did not focus adequately on training them to play a Health Trainer's role. This was partly reflected while reviewing the training methods used to train the VLWs. Therefore it is suggested that the Sub zonal Coordinators need to be trained by CHRSE in understanding learning processes and specific training techniques.

ii) It is suggested that in order to enhance the credibility of the examinations of the VLWs, instead of having a one man Board, though he is extremely competent, professionally

objective and has been very strict in conducting examinations for the VLWs, yet his being a prominent member of the organisation, it would be strategically very important to constitute a three members Board of Examiners with alteast one of the members being outsiders.

iii) Yet another suggestion in this regard would be, that the newly trained VLW would require very close supervision by the Sub zonal Coordinators through the initial period which may vary according to individual differences. this factor should be given serious consideration in planning the work allotment of Sub zonol Coordinators and a feedback system to assess the performance of the new VLWs for a span of 6 months, soon after allotment of drug kits, would be very crucial. It is noticed CRHSE that is little weak in the followup of newly trained VLWs.

iv) It is recommended that CRHSE should give adequate emphasis to refresher courses for VLWs and such periodical updating of training would be vital in enhancing the competence of the VLW on the one hand, and in strengthening the VLW component of the three tier model of CRHSE, on the other hand. We are fully aware that such refresher courses do exist presently. Our recommendation here is to intensify this process of continous updating of VLW training.

Reviewing the Programmes against the Objectives

Assessing this component of the health programme, namely, building of Health Cadres, we reproduce below the relevant extracts from 'Yonder the Hills', page 3.

> "**Building of Health Cadres:** By now it is evident that even ordinary village people can be trained to undertake a considerable degree of responsibility for health care in their own communities. Therefore, this programme envisages training of village young people, as an integrated group, which will render health service in the communities. This is an experiment to try out the concept of 'barefoot doctors, and to demonstrate that individuals without previous medical background can be recruited and trained locally to deliver health care in villages"

The analysis and critical examination of this component of this probgramme, as extensively written in this chapter, *indicates beyond any doubt that the objective has been accomplished to a tremendous extent, in creating barefoot doctors. It should be stated in uncategorical terms that accomplishment of this objective has been ABSOLUTE.*

The social transformation brought about by this programme, indicates the far reaching social implications of the concept of Building Health Cadres from the people. These inferences are dealt with separately in the last part of this chapter.

4. Health Service Scheme

The third component of the health programme of CRHSE is the Health Service Scheme. We reproduce below from 'Yonder the Hills', page 3 under the heading, Health Service Scheme.

"The present health service is predominantly illness oriented, expensive, personalised and consequently unsuited to the needs of most of our people. Therefore, our schemes provide for a helath service which is inexpensive, simple and practical for those in need of assoistance and service, using existing facilities adopted to the needs and conditions of the community. This will also serve as a base for both health education and for the eveolution of responsibilities to adequately trained health cadres at local village levels."

The health service scheme will include the following essential medical aspects:

1. Ante-natal and post-natal care
2. Under fives care: checkups, immunisation monthly follow-up and nutrition advice
3. Leprosy detection and treatment
4. T.B. detection and treatment
5. V.D. detection and treatment
6. Dental care – oral cancer detection and treatment – preventive dentistry and dental check ups. ....."

Introduction

As it was mentioned elsewhere in the report that for operational purposes the health programme has been classified under three major heads, namely Health Educaton Programmie Building of Health Cadres and Health Servce Scheme, yet one cannot avoid overlapping.

The Sub zone Cenre which is the operatonal unit of Health Service Scheme covers most of these programmes. However, we acknowledge that the evaluators did not collect data or correclate data gathered at different Sub zones to assess as to what extent these programmes have been implemented. Therefore it will be unfair to make any comments on this component of the programme.

Tentative Inferences

It is also pertinant to point out here, that one cannot avoid providing a running thread to a programme, which interlinks the three different components of CRHSE health programme. For eg. if we consider ante-natal and post-natal care as a programme, this component has to be covered under Health Education and the VLW should provide adequate emphasis through health education to this aspect, and only then it will result in the Health Service Scheme adequately covering ante-natal and post-natal care at a clinical level at the sub zone.

If this is assumed to provide an indicator to assess the Health Service Scheme, then one is not very sure to what extent programmes like leprosy, T.B. and V.D are covered. Though dental care has been covered extensively in the Tirupathur zone, the other zones do not cover this component to the same degree.

Yet another tentative observation would be that most of the cases covered at the Sub zone level related to common flu malaria, allergies and skin diseases. To some extent ante-natal and post-natal and the care of the under-fives have been covered.

We repeat again that these inferences are very tentative and we leave it to the members of the organisation to further review the observations mentioend in the preceding paragraphs.

Overall Review of Health Programme

A. Critique of the three tier health delivery system

Assuming that the CRHSE programme is built on a 3 tier system namely ordinary and simple health problems being dealt with by the VLWs at the lowest tier; certain ailments and difficult cases which are beyond the scope of VLWs being referred to the Sub zonal centres (wherein treatment is provided by the Sub zonal Coordinators) at the middle tier and; complicated cases if any, which require specialitts medical attention being referred to Medical Consultants who are available once a week at each Sub zonal Centre, at the top tier.

If this is envisaged as an alternative model, then it should be assumed that there is an inbuilt referral system, the patients moving from VLW to Sub-zone Centre and from Sub zone Centres to medical consultants. We found that between the Sub-zonal level and mecical consultants' level the link has been completely established; however there is no such link between the VLW and the Sub zonal Coordinators. In other words, very tentatively it can be stated that only 2 or 3 out of every 10 patients seen by a VLW do make use of clinics at the Sub-zonal Centres.

The Sub-zonal centre mostly treats independent cases. In other words the remaining 7 or 8 patients visit either the private practitioner in near by towns, or go to the government hospitals.

One should also take cognisance of the fact that a new and growing phenomenon is visible here in the form of private practitioners coming away from towns to semi-town areas and establishing private practices. A good number of them are Homeopathy certificate holders, who never the less, practice Allopathy.

The significance of this datum is that, if the link between VLW and Sub-zonal level is not established, then the probability of the VLWs role becoming insignificant is greater. It is further viewed that, when the patient seen by the VLW goes to some other hospital or medical practitioner, the VLW does not become part of an alternative health delivery system and there is every probability of the VLW being viewed as a mere first aid administrator.

Alternatively, if the VLW refers the difficult cases to the second tier, the Sub-zonal centres can have a greater scrutiny over cases treated by the VLWs and further educate the VLW in making appropriate references and probably the patients can even be referred back to the VLW, for followup. In such an event the village community would see the vital link and the role played by the VLW and the image of the VLW will be further strengthened.

On the other hand when the Sub-zonal centres treats patients independently of the VLW, the chances are greater that the Sub-zonal Centre will be viewed as a mini health centre and not as an integral part of an alternative health delivery system.

The crux of the matter is that if the VLW is a vital unit of this alternative model, then, strategically, it is crucial that this unit is strengthened. It should become the most powerful unit, especially because, their low educatioanl level, when combined with low performance increases the probability of this tier dis-integrating into oblivion by gradually performing the role of first-aid administrators and eventually more or less turning into a village medical shop.

Therefore, there is tremendous need to constantly strengthen the VLW position and build the crucial link between the VLW and the Sub zone Centre.

B. Highlights

i) Recovery of Medicine Cost

A special emphatic reference has to be made regarding the cost effectiveness of the programme. It is remarkable to note that the entire cost of medicine, that is roughly about Rs. 80,000/- per annum, has been absolutely recovered from the people. In another words, people pay for the medicine to the VLWs and when ultimately VLWs become autonomous, without becoming dependent on CRHSE, VLWs can successfully continue the treatment as the medicine cost is paid by the people. *This should be considered as an extraordinary accomplishment.*

ii) Exploding the myth:

Yet another most strking feature of VLW training and the functioning of VLWs has been the *explosion of the myth* that knowledge is available only to the privileged and particularly that medical knowledge being the prerogative of doctors representing the elites; the myth that the common man cannot understand the causes for his ailments, leave alone treating them, has been disproved. Medical knowledge and the profession being represented by the elites has resulted in mystification of medical knowledge and the common man, particularly the poor is not supposed to know anything concerning the diseases that he is suffering from.

This typical alienation of the medical expert from the patient is an organic part of our socio-economic system. This not only has mystified the medical profession but has also commercialised it.

The programme of CRHSE has explored this myth and operationalised an alternative health delivery system in which ordinary people can hold the key to the power, namely, knowledge, particularly knowledge concerning their health.

Thus the model has deliberately transferred this power from the experts to the ordinary villager - on an average, a VLW being educated till the 8th standard. To cite an extreme and expcetional case even, an illiterate has been trained as a VLW at the Yelagiri hills subzone.

This empowerment on the part of the VLW has indicated the fact to the villagers, that knowledge and empowerment is within their reach.

What was interesting to observe during the evaluation was the rustic and simple VLW being respected and even referred to as 'doctor' in that area, to the extent that often people expressed their desire that the VLWs should be trained further so that they could administer injections.

There is a common belief among the villagers that only when they are given injections, even if it is distilled water, the disease will be cured.

iii) Social Implications for the VLWs

The preceding paragraphs bring to light yet another important outcome of the programme. The social status of the VLW has been tremendously enhanced and the VLW is looked upon as an important person in the village. It is certainly possible for the VLW, with this newly acquired status, to provide leadership to their respective village communities, though this status has had to be earned by each VLW by his or her sheer performance.

C. Social change brought about by the health programme

It is pertinent to bring out certain significant features of the programme which has far reaching social implications. It is interesting to note that though the VLW porgramme is primarily a health programme it has resulted in significant social transformation.

We would like to refer to few cases where the VLWs are drawn from the Caste communities and CRHSE has laid out firm conditions right at the very beginning, both to the VLW and to the respective community, prior to the VLW training, that the VLWs are to cover both Caste and Harijan communities. Secondly, it has been made essential for the VLWs to visit the Harijan community and treat the patients there too. Though this was a problem in the beginning, today, after the programme has been implemented for nearly half a decade, this problem has been resolved.

In our opinion, this is a very significant component of the programme. We found particularly in the case of Caste women VLWs, partly due to their economic status, the colse rapport and interaction between the Caste VLW and Harijan community has been eventually accepted after initial resentment.

This is very significant, for in Indian villages caste norms are to be strictly followed.

One can go one step further and hypothesize that the functional interaction between the Caste VLW and Harijan community is slowly leading to accepted forms of behaviour in the village and that the 'mores' are changing. This may eventually give way to other interactions b tween the Caste and Harijan communities whereby, it will be feasilbe to organise the poor on class basis overcoming caste bottlenecks.

This very simple interaction is lessening the strict norms of caste rules and the willingness on the part of the Harijan community to freely interact and even share a meal with a Caste VLW is slowly destroying the myth of their being inferior.

Analysis of comparati ve approaches to social change

We strongly feel that this approach to caste is having far reaching significance and even changing the caste system.

It is interesting to note that whenever social action groups directly take issues related to caste and provide awareness on caste related issues, it eventually leads to confrontative strategies and the results are disastrous.

The caste groups being econonically prominent, politically powerful and having immense capabilities of organising themselves, any confrontation leads to fatal blows to Harijan communities. This results in caste tensions growing stronger and eventually, the Harijan communities losing interest in 'organising' themselves. To cite an example nearer home, about 150 kms from the project area at Villupuram, a caste conflict led to more than 200 huts belonging to Harijans being burnt and about 20 Harijans being burnt laive.

Such violence on the one hand strengthens the caste system, the high caste groups getting closer and resisting more vigorously and changes in the behaviour pattern of the socially oppressed people and concomitantly, it destroys what little hope the Harijan community has in organising themselves to resist the social exploitation.

A Hypothesis on the process of social change

A process of the kind CRHSE is initiating brings about change through an unconscious process. It could be surmised that caste groups are not aware of this process occuring right under their noses. This further proves that social change involves a gradual process and when it is ushured in silently and subtly, through indirect means, as it is in this case, there is very little resistance or opposition from vested interests, thereby making the phenomenon of social change a reality.

A significant strategy in the area of social change

It would be far more interesting to see, if increasingly VLWs, are selected from the Harijan community and, if, they are eventually accepted as health workers among Caste communities. When that happens, CRHSE certainly would be achieving something substantial in the area of social change.

We also feel that it is possible to accomplish this, for, when initially, some village communities resisted Caste Hindu VLWs working in Harijan communities, CRHSE refused to introduce the programme in these villages. Eventually, when there was no other option left, other than seeking assistance from the same VLWs who were also treating Harijan community members, the Caste communities gave up their resistance.

Similarly, it could be premised that Harijan VLWs may be accepted as Health Workers in caste communities, if no other medical facility is available.

It could be hypothesised that only such mode of informal practice can erode deep rooted myths and reduce social controls governing caste practices in the villages. This particular aspect requires greater study and very conscious strategies need to be formulated to strengthen this process further.

D. Conclusion

To sum up, after thoroughly reviewing all the operational programmes classified under the three major components, it should be stated in uncategorical terms, that the creation of barefoot doctors has been the most outstanding accomplishment of the health programme.

Despite the critique provided in this chapter relating to the functioning of the three tier system, and the Health Education Programme taking a lower profile in comparison with curative aspect covered under the Sub-zone clinics, never the less, the process of social change initiated by this programme outweighs the limitations that have been persistently pointed out throughout tthis chapter.

CHAPTER IV

Social Development and Education

1. Introduction

CRHSE's main line programmes are – Health and Social Education. In this chapter, the assessment is related to Social Education Programme. At the outset we would like to observe that one should take cognizance of the fact that the results of Social Education Programme cannot be visible and measurable in tangible terms as compared to the Health Programme. It is also pertinent to review Social Education Programme against a frame of reference of social and political scene, in a given geographical region for, the Social Education Programme directly relates to the socio-political situation. Therefore, we provide the hisotrical perspective and then, against that frome of reference, we will assess the Social Eudcation Programme of CRHSE.

2. Historical Perspective

One has to first look at the programme in its historical context. Since Tirupathur taluk experienced a politically explosive and volcanic phase during 1978–83, the fact that a programme like this could survive in that area itself, is enough proof of the commitment, dedication and courage of the CRHSE 'leadership' and the 'team'. It is common knowledge that CRHSE was under very close government surveillance and perhaps, it is not necessary to mention here, the extent of psychological pressure that was put on the CRHSE leadership, in particular, and on the team in general. *If one misses this factor, then perhaps one would miss the entire meaning of this evaluation.*

3. Objectives against which Social Education has been reviewed

We reproduce below from *Yonder the Hills*, which is the project proposal of CRHSE, under Part B, I, page 5, objectives 1 and 2:

i) Social Education Programme

"Education in basic communities such as the ones in Tirupathur is not so much a matter of reading and writing a language, but education for life itself. This can be achieved only through certain type of functional literacy programmes. What is meant by functional literacy here is an educational programme in which the labourers learn, through their problems the basic mechanics of their society itself. In this way they will acquire a framework in which such facts of their life as exploitation, causes of poverty, ill-health, patterns of capital and land ownership, labour relations and rights of citizens, etc. become de-mystified and begin to be seen as being capable of being changed through appropriate collective action. Only this type of education can enable leadership to emerge from among these communities for the process of the transformation of their societies"

ii) Forming Unions of Agricultural Labourers

"The strength of the people becomes a reality primarily in their unity, and this is especially so in the rural agricultural areas. Unlike the modern industrial and urban sectors which are organised. This is a calamity in a developing country like ours. Hence, this programme will endeavour to form unions of the landless labourers at village level as a means of consolidating their power and strengthening them in their efforts to establish their rightful place in the field of agricultural production and to set up models of collective ownership and production.....".

We further quote from the same document from Page 26 weich operationalises the above said objectives into specific programmes.

iii) "The other aspect of the economic programme is to provide skills in order to sharpen the bargaining power of the labour force. This cannot be achieved though subsidies or by providing funds for establishing small scale industries. The management of such ventures by extraneous hands would eventually erode people's initiative and thereby putting a premium on people's participation.

In the present set up, the agricultural labour force is exclusively dependent on agriculture. During the season, labour becomes surplus and the bargaining power increases on the part of the land owners and hence a climb down in wages. The skill training programme is to create alternative employment, and logically augment the bargaining power of the farm workers. . . .".

4. Operationalisation of Social Education

With reference to the aforementioned objectives, we can premise that the Social Education components has been 'operationalised' and incroporated into various programmes. We can cite the following programmes wherein the Social Education process has been incorporated.

i) Organisation of cultural programmes through communication media like drama, puppetry etc. which were organised in the villages communicated the social education programme.

ii) Organising youth clubs, women groups and villages development councils is yet another operational unit of social education programmes.

iii) The incorporation of social education components in the VLW programme and the functions of VLW itself is yet another operationalisation of social education programme.

5. Youth and Women groups

To provide specific evidences we give below the list of youth and women groups that have been organised in the 3 major zones since the beginning of CRHSE.

Tirupathur Zone

i.	Pudu Poongulam	Y group	1984/85
ii.	Bommikulam	Y group	1979
iii.	Sowdakuppam	W group	1982
iv.	Pudur	Y group	1984
v.	Kathirampatti		1983

Jayapuram Zone

i.	Jayapuram	Y group	1979
ii.	Chandrapuram	W group	1984
iii.	Veeramustipalli	W group	1984
iv.	Purandapalli	W group	1984/85
v.	Paniyandapalli	W group	1984/85
vi.	Kizhakkumedu/		
vii.	Chettipatrai		1985
viii.	Naricheri		1985

Vaniyambadi Zone

i.	Vallipattu	Y R SC	1978/79
ii.	Karumpatti	Y group	1979
iii.	Chekkumedu	Y group	1979
iv.	Ballapanur	Y group	1979/80
v.	Thimmanoor	Y group	1984
vi.	Kurumpatheru	Y group	1984
vii.	Kodiuyur	Y group	1984
viii.	Kannadikuppam	Y group	1985
ix.	Thuraiyeri	W group	1984
x.	Govindapuram	W group	1984
xi.	Nachiarkuppam	Y group	1985
xii.	Kathakottai	Y group	1985/86

6. Limitations of the Evaluation

We can not make an assessment on the character, functions and scope of these groups for the evaluators did not scientifically use a sampling methodology to select these groups for interaction in order to make an assessment. However, the evaluators did meet members of 4 sangams in different zones. Based on this limited interaction with these groups we refrain from making any assessment on these groups. Moreover, a sizeable number of groups are less than one year old and an assessment on the basis of their functioning will be erroneous.

6. 1. Note of caution

Identifying groups that are disintergated and considering it to be a failure of social education programme, will be erroneous for one has to bear in mind the following factors while making an assessment of youth groups:

i) The very nature of youth groups being transitory one cannot expect the same youth club to function perennially.

ii) When open conflicts do occur in class struggles, on account of economic dependencey on the landlords, the sangams get disintegrated due to the onslaught of power structures eg. Vallipattu group.

7. Accoplishments

A. Vaniyambadi Area

The struggle initiated by the Vallipattu youth groups during 78–79 resulted in a wage rise among the landless agricultural labourers. Arranging of loan from the banks to the landless labourers increased their involvement in the village panchayat which was earlier dominated by the landlords and the village heads. These activities initiated by nearly 7 groups in different pockets of Vallipattu area can be treated as achievements.

B. Jayapuram Area

i) After the initiation of social education programme at Jayapuram area in 1978–79, the practice of providing separate glasses for Harijans in the teashops was removed. Harijans were able to go to a common place and sit and chat with the other members of the village.

ii) Youth groups took up the issue of land pattas for Harijans, took a few processions to Tirupathur government offices and though they are yet to get the pattas, the process is on.

iii) Youth group got loans from banks for 10 families.

C. Tirupathur Area

At Bommikulam, the youth group was able to get a foothold into the village panchayath to fight for justice for their own people. Few youth groups got loans from Banks for the people.

Despite the said accomplishments there are not many such illustrations though one would anticipate more such illustrations from a programme of this kind.

8. Reviewing the Programme against the Objectives

With specific reference to objective No. 1, based on the above mentioned data, we can infer that as far as this objective is concerned, substantial accomplishments have been made viewing it in the historical context.

With reference to *objective No. 2, forming of unions of agricultural labourer*, we can infer that this objective has not been accomplished.

Further, refering to *objective no. 3, relating to initiating alternative employment opportunities to augment the bargaining power of the farm workers,* in operational terms is closely related to *objective 2 of forming unions of agricultural labourers.* It is observed that this objective has not been accomplished.

9. Factors contributiing to non accomplishment of aforementioned objectives

While examining various factors that could have attributed to non accomplishment of social education goals, we review it under the following heads of objectives:

9. 1. Implications of the poliical climate for CRHSE

In all probability, on account of historical circumstances and the political climate, strategically it may have been necessary to take a low key profile with regard to Social Education programme. It is also probable, that the low key position stuck on, as the well defined Health Programme eclipsed the Social Education Programme. Thus, due to historical factors, on the one hand, and the Social Education Programme not being well operatiomalised on the other hand, it could have led to the marginalisation of Social Eudcation Programme.

9. 2. Organisational Factors

Yet another significant aspect related to the organisational structure, reveals certain lacunae responsible for the low priority given to social education programme. It is premised that the crux of CRHSE revolves around the Sub zones and the Sub-zonal Coordinators are the key functionaries. Presently, there are about 10 villages under the each of the sub zonse. Almost all the Sub zonal Coordinators have a Health background and primarily play a Community Health Guide role, the only exception being in the case of the cooprdinator or Netajinagar special project to furhther substantiate this inference later in this report we are making special reference to Netaji nagar special programme in the context of the Coordinator being Non-Health person.

9. 3. Work Study

The Sub zonal Coordinators spend the entire morning hours in running the clinics. One afternoon a week goes for VLW theory training. Each Sub zonal Coordinator spends most of the evenings visiting VLW villages and supervising their work. Some of the VLWs, being newly trained, require greater guidance and attendtion. As a result, two visits in a month to a VLW area would literally cover the entire month apart from addiional programmes like the School Health Programme; Communication Team programme Mass Level Immunisationprogramme; etc. Therefore, due to the work load, invariably a Sub zonal Coordinator spends maximum of six hours in a month with local groups – may be a womens group or a youth group. The pattern at present is that, each Sub zonal Coordinator spends two to three hours in a month with a youth group and two to three hours with a women's group.

9. 4. Expectations from VLW

This data reveals that the social education programme presently receives very low priority in its operational form. It is unrealistic to expect the VLWs to play an active role in the social education programme as they are primarily volunteers, inspite of the fact that the non-autonomous VLWs either have their own agricultural receive a sum of Rs. 30/- per month. By and large, the VLWs either have their own agricultural work or, employed in the midday meal scheme of the Tamil nadu government. Some of them are traditional dais. It seems that on an average, a VLW sees about five patients in a

day and is also involved in any preventive measures initiated by CRHSE in his/her village. It is not practical to expect anything more from the VLWs who are not playing any significant role in the context of Social Educaiion Programme.

9. 5. Role of Zonal Coordinator

This leaves only the Zonal Coordinators. Each Zonal Coordinator is directly responsible for about 30 villages and supervision of Sub zonal Centre. The Zonal Coordinators do take up quite a lot of administrative responsibilities as they primarily provide the link between the zonal offices and the central office. It is also the responsibility of the Co-ordinators to supervise the work carried out by Sub Zonal Coordinators. In this context, it is rather difficult to expect the Zonal Coordinators to directly work in the villages which are scattered over a radius of 60 kms because they will not be able to provide adequate, if at all any, support to the social education programme, as revealed in the aforesaid analysis of the organisational structure. This is further reflected in the form of the social education programme not being operationalised as meticulously as in case of the health programme.

10. Critique

Therefore, our critique of the Social Education programme would be that it lacks the operational form. Here again, beyond a point, mere debate and discussion on socio-economic contradictions and class conflicts would be futile, however essential such polemic discussions may be. The awareness of socio-economic realities has to be translated into programmes not necessarily through a confrontrative model, though one does not disapprove of such a model. Yet pragmatic programmes need to be evolved to keep the sangams growing.

11. Recommendations

In this regard, we would suggest, for the aforementioned reasons, that CRHSE may fill in the vaccum in the area of Social Education Prgoramme by filling in personnel to do the job. Our recommendation would be that, CRHSE should create complementary Social Education Sub zonal Coordinators at each sub zone to carryout the Social Education Programme. Then, it would be possible for the Zonal Coordinators to coordinate the Sub zonal centre and cover 30 villages that are presently covered in each zone. It is further recommended that the Social Education Programme needs to be operationalised.

While one sees great potential in women's groups and youth power, one should not neglect organisation of people on occupational basis. We would also recommend to CRHSE to look at the concept of sangam model of development. The Social Education Programme can play a great role in initiating and forming these sangams and can constantly help them to formulate programmes which would be the nerve centre of these sangams and sustain them. The role of Social Education Coordinators would be one of constantly offering leadership training camps to the sangam leaders to provide awareness on the one hand, and to develop their leadership on the other. Such an interaction would complement the health component of the programme. Lack of this component, both at the community level and at the organisational level may turn CRHSE programme into a simple health programme which is not the objective of this project.

CHAPTER V

Netaji Nagar Special Project

1. Origin of the Project

This programme began as a consequence of floods in Palar river which dislocated three thousand families who were residing on the banks of the river. A segment of people, who were dislocated, migrated and settled, at a place called Netaji nagar. To begin with, this was a programme initiated by one Mr. Dearmun who sought CRHSE's assistance specifically with reference to health related issues. CRHSE supported this programme quite extensively right from the beginning. At a later stage, it became clear that merely dealing with issues related to health would be quite inadequate and work related to other aspects of community organisation was also needed. CRHSE's involvement grew stronger in this direction too. Eventually, a stage was reached where CRHSE could not merely provide support services because of the intensity of the work and thereby it became crucial to decide about CRHSE's stand and future direction with regard to Netaji nagar project. Mr. Dearmun who, originaly intitated this programme, became fully aware that the subsequent developments at the project area required fulltime professional support. Therefore Mr. Dearmun requested CRHSE to take the total responsibility of running the project. Thus came under the wings of CRHSE, the Netaji nagar special project.

2. Location of the Project Area

A note has to be written about the nature of the place. Netaji nagar is situated on the trunk road fowards Madras near Vaniyambadi. Therefore, it cannot be described as a rural area, nor can it be described as an urban cetnre. It is on the outskirts of the Vaniyambadi town sociologically speaking, having suburban characteristics. In these settlements presently 1,200 families are residing. The primary objective of CRHSE with regard to this project has been to provide health services on the one hand, and to create social awareness and organisation of the people on the other hand. The programme has been headed by a Coordinator who concentrates primarily by a Health Programme Coordinator who heads the health programme. Most of the residents of Netaji nagar area employed as casual labourers in the tanneries which are flourishing in and around Vaniyambadi area. It is interesting to note that muslim community constitutes a sizeable section in this area.

3. Achievement of CRHSE

CRHSE has been functioning in this area since 1979. The achievements of CRHSE can be described under two broad heads namely 'social education' and 'health'.

A. Social Education

Under the social education programme remarkable achievements have been through the process of social action:

i) By organisation and mobilisation of the settlement dwellers, they could obtain 'permanent pattas' from the government for the land on which they were residing ever since they were dislodged from the banks of Palar river.

ii) Again through social action the government authorities were pressurised to provide pacca roads in the settlement area.

iii) Availability of clean drinking water was a major problem in the settlement area. Through social action process the government was pressurised to instal tube wells in the settlement area.

iv) Since the settlement area is a little remote from the town, again through social action process, the gvoernment was pressurised to provide electricity and streetlights to the entire area.

v. **Coping with environmental hazards**

Presently a process has been initiated by the members of this community to initiate public opinion on the one hand, and to bring to the notice of concerned government officials the tremendous damages that have occured as a result of effluents from the tanneries, being lead to the land surrounding the settlement area. This posses two major problems:

- firstly, wherever the stream if effluents has passed, the soil has lost its fertility and absolutely nothing grows. There have also been reported istances of cattle death occuring on account of drinking water from the ponds in which the effluents have mixed.

- secondly, there is a greater probability of the effluents seeping through the land and affecting the ground water which is presently the major source of drinking water to the 1200 families settled in this area

vii) The most significant aspect that stands out in all the above said achievements has been that all the accomplishments have been as a result of a communityorganisation process by CRHSE predominently through women's groups. As a result of this process, the people could come together and organise themselves, and through their own leadership and collective strength, by demonstrating this strength to the representatives of the government, were able to resolve most of their problems.

vii) Yet another significant achievement in this are has been organisation of muslim womens associations. This should be specially emphasised as a significant fact for culturally the constraints to organise Muslim women are too many.

B. Health Programme

In the health aspect, presently there are seven VLWs covering almost the entire population. What is very significant is that all 6 VLWs are women and 2 of them are Muslims. As in other areas, the knowledge and skill level of the VLWs was found to be good. Their motivation and commitment level is very high and their acceptance by the community is good.

4. Suggestions

A. Background against which Suggestions are put forth

Reviewing Netaji nagar programme with reference to CHRSE's programmes as a whole not withstanding the fact that comparisons in the light of so many variables is erroneous, one could still easily identify a much greater success and more impressive impact of social education and social action in Netaji nagar programme. Two probable factors which could have contributed to this are:

i) The Netaji nagar has the attributes of a semiurban community and thereby the processes of community organisation could probably be easily accomplished. For eg. in this case, one could clearly identify the target authorities, namely, the Sewage and Water Development Board for borewells, Chief Engineer of Electricity Board for electricity and so on. These specific targets could be pressurised through mass processions and dharnas carried through the streets of the town which easily brought issues to the notice of the public on the one hand and certainly an eyesore to the administrators. Therefore it could be argued that it was feasible to have far greater accomplishments on the social education side of CHRSE programme in Netaji nagar.

ii) Secondly, it can also be argued that the success could be partly attributed to the fact that Netaji nagar special project has always had a Coordinator who is basically a Community Organiser and not a Health Worker.

B. Unionisation Process as a Strategy - A Suggestion

It is observed that the mobilisation of people has been based on the principles of community organisation. It is true that people did and do come together on issues related to their basic amenities. What is questioned here, is whether this process could eventually manage to build a peoples organisation which would be sustained by its own efforts. Secondly, though the process involved a tinge of social action, never the less it is questioned whether it is disguised scoial service in the form of social action. Viewing it in the context of the issues of the people residing in the settlement areas the basic issues are predominantly related to their nature of employment, wages, working conditions and other related issues. Owing to the fact that most of the people's employment in the tanneries is of casual nature, facing very severe health hazards and particularly because none of the labour legislation can be applied as they belong to the informal and unorganised sectors it is suggested whether it will be more rewarding if CRHSE considers organising the people at the Netajinagar on trade union lines and the process of unionisation though time consuming will have a strong class element.

CHAPTER VI

Assessment of the Organisation

1. Commitment of the Staff

The most significant aspect of any organisation is its staff for, it is they who constitute the organisation. Therefore the crux of any project is based on the quality and mettle of the staff. Here is heartening to note that the entire staff team of CRHSE, 19 of them, are 'extremley committed', 'totally dedicated' and very 'simple people'.

The fact that almost all the staff have put in an average of about 5 years of service with CRHSE and that its staff turnover is low, is remarkable. Further, the 3 Zonal Coordinators who are the main pillars of CRHSE, have been with the project since its inception.

2. Organisational Climate

In addition the fact that there are about 3 VLWs who have risen to the Sub-Zonal Coordinator's level, exemplifies the growth potential offered by the organisation to it's staff. Moreover the smooth and cordial working relationships that exist at CRHSE from the VLWs to the Director's level is yet another indicator to indicate the existing organisational climate in CRHSE.

This phenomenal strength of CRHSE, should be viewed against the prevailing general development scenario, particularly with specific references to Tamil nadu. It is a common feature that the development personnel at the middle level, are really a 'moving force'; a moving force, in the sense that they move from one project to another. This migratory character of middle level workers is partly due to their dissatisfaction with their job, and partly on account of the prevailing organisational climate. Therefore most projects reveal a very high staff turn over. In certain cases the organisation may keep the staff turnover rate relatively low by alluring the staff to stay on by offering higher incentives. Therefore, it is essential to relate turnover with salary structure.

3. Assessment of staff Motivation

With reference to CRHSE, it's salary structure has been extremely low until recently, and after certain administrative changes, it now appears to be little satisfactory, though still on the lowerside. Therefore, the low staff turnover at CRHSE cannot be attributed to remunerative factors. From the aforesaid analysis, it can be inferred that despite the salary level being low, the majority of the staff have stayed with the project almost from the very beginning. This is to be particularly appreciated taking into account the historical factors, that terribly affected North Arcot and particularly Tirupathur in the late seventies. If the CRHSE team has stayed on inspite of heavy odds, it proved beyond doubt that the *motivational level of the staff has been* extremely high and the quality of leadership which induced, nurtured and sustained the motivation and morale ought to have been exemplary.

4. Strengths of the Organisation

It is further observed that certain trivial matters, though seemingly inconsequential, provide significant indicators to assess an organisation's strength. In this context, we observed that:

i) The style of leadership is informal, democratic and human

ii) The salary differences between the rank and file is marginal

iii) It was observed that there is very high degree of discipline on the part of the staff whether in the field or at the office

iv) A most uniformly the living style of the staff is very close to the people with whom they are working. There is no question of a sense of alienation occuring between project staff and the beneficiaries, which is becoming a common phenomenon in most of the development projects.

v) matters like punctuality, availing of leave, handling of project money at all levels, and formulating procedures for accountability of work etc, are strictly adhered to with highest principles of management.

vi) lastly, and most importantly, the pattern of expenditure as revealed in the Auditor's Statement of Accounts clearly indicates as to how this massive programme is organised with use of minimum of funds. This is another proof for high degree of accountability and efficient financial management at CRHSE.

5. Leadership

It should be acknowledged and recorded that to a very large extent, the credit for the organisational strength, the high motivational level, the morale, the deep sense of commitment to the cause of people, and the high degree of professional efficiency and competence should be attributed to the leadership. It is further reiterated that this style of leadership itself is replicated through the process of zonalisation. There is very little doubt that this role model would definitely have a positive impact on the rank and file of the organisation.

6. Weaknesses

While it is important and imperative to identify and acknowledge the strengths of the organisation, it is equally important to bring out the weaknesses that are noticed in the organisation. It is possible to translate these weaknesses into strengths which could contribute to the growth and efficiency of the organisation. It should be acknowledged that after all, organisation is only a form of operational means to carry out our primary task, our primary task being, ameliorating the conditions of the people who live below the poverty line and to whom we are all committed.

6. 1. It is observed that the CRHSE staff have not had much exposure to other development efforts that are being carried out both in Tamil nadu and other parts of the country. This closedness, if one could call it so, can stagnate the growth of CRHSE in two ways.

Firstly, in the absence of exposure based reflection one tends to draw more from theory and rely on ideology. This may lead to a dogmatic approach, however pragmatic the programmes may be.

Secondly, if one is strong about one's ideological base, then the strength does not come from exclusiveness. On the contrary, interacting with opposing ideologies can further consolidate its position. However, it should be remembered that only when it is tested can one be certain that an ideology caters to the people and we have to be constantly aware that our concern and priority is not ideology, but people.

6. 2. It was observed that the staff at CRHSE had very little training either by resource people from outside coming to the organisation, or by way of their attending training programmes conducted by different training agencies in and outside Tamilnadu.This aspect of not giving priority to staff training and development, particularly, in not availing of the variety of existing training opportunities can be viewed in conjunction with the observations made in the preceding paragraph relating to relative isolation and exclusiveness of CRHSE. It can be inferred that CRHSE is not very open for communicating with other groups. If this assumption has any source of truth, then it reflects a dangerous trend, for people's movements' and processes of change can never be brought about in micro contexts. Further, it may block the learning and growth potential, not only of the project, but also the people on whose behalf we are initiating and facilitating a historical process of change.

7. Suggestions

It is suggested that CRHSE can critically review this assumption and if such an analysis does indicate any insights on the lines premised above, CRHSE should evolve an appropriate course of action.

8. Conclusion

To sum up, CRHSE has evolved an organisational structure, a development sub-culture and an orgnisational ethos which reflects an ideal mix. CRHSE is a classical blend wherein freedom is provided through a process of decentralisation, yet accountability to the central office is valued; while democracy is practised, authority is respected, informality is the style of functioning but uniformity is seen everywhere; hierarchy is not visible; but roles are well defined. Rules and laws are not explicitly framed but descipline is practised to the highest order. While simplicity and humility is the culture, professional competence and efficiency is the motto.

To sum up, CRHSE as an organisation, in it's organisational aspect, is no doubt *an outstanding organisation*.

CHAPTER VII

Note on Internal Self Evaluation

It is observed that a programme of this nature should evolve well defined systamatic parameters and indicators to constantly monitor whether the programmes are able to accomplish the desired ends. Secondly, such reflection would help to identify bottlenecks at the implementation stage and to take corrective action. Thirdly, an open feedback system would be tremendous source of support in strengthening the programme – as well as the organisation and above all the morale and commitment of the staff.

It was observed that CRHSE is yet to develop such an evaluation model. The following suggestions could provide a broad frame of reference to ponder further on these lines:

* firstly, with respect to the health programme, since the programme has been operationalised in tangible and definite terms, it will be feasible to evolve the pre programme, data and assess the probable impact on the beneficiaries. For eg. if a new village has been adopted for the programme, the data available at CRHSE presently refers only to those who have taken the VLWs assistance in health matters. Similarly the data available at the Sub zonal centre again refers to those who have taken the assistance from the Sub-zonal centres.

* since the respondents here are very selective, one feels the difficulty of ascertaining the true impact of the programme on the total community, for in this system of monitoring, the 'universe' is never taken into account. For eg. if CRHSE is working in a particular village, consisting of 150 families, out of the universe 25 patients visit the VLW on an average of 10 times per year, this would amount 250 cases. Here again if the 250 cases includes indiscriminately cases ranging from minor cuts, malarial cases to oral rehydration, the data will be misleading for the nature of the diseases are signiaficantly different.

Supposing in the absence of well defined classification of diseases, hypothetically, all the 250 cases are for cuts and simple cold and cough and, on the other hand the remaining 125 families have had occasion to visit a doctor on an average 10 times a year, whether a private practitioner or government hospital. Then the total number of patients who availed of different medical services in a given year is statistically 1500, out of which, the cases seen by the VLW is 250 or 14% Carrying this analogy further, even /these / if 14% of cases were for cuts and common cold then, the inference would be that the impact of the VLW on this particular village is absolutely nil despite the fact that the statistics show that the VLW has seen 250 cases.

Alternatively, if in the same village the total number of cases whatever they may be being treated by VLW, private practitioner, government hospital or the Sub zonal Centre, were to be hypothetically 500, and,if the cases seen between the VLW and the Sub zonal Centre were

to be 250 or above not considering cuts and cough, then, it could be said that the impact of CRHSE health programme in this particular village is remarkable.

The above 2 illustrations would elucidate the point that:

- definition of cases that occur within the universe
- total cases that occur within the universe
- classficaiton of the cases that are treated at VLW level as 'insignificant' and 'significant' cases would provide a valuable frame of refernece to assess the impact of one of the aspects of the health programme.

This example has been suggested to bring out the point that both the health programme as well as the social education programme can be demacrated into well defined units and therefore objective, tangible and measurable indicators and parameters can be evolved by CRHSE to assess the effectiveness of their programmes on a periodical basis. Such an effort would further strengthen CRHSE programmes tremendously. The purpose here is not to provide readymade parameters, but to suggest that it will be possible for CRHSE to evolve scientific tools to measure its work in qualitiative terms through a process of self evaluation.

CHAPTER VIII

Note on Training

1. Training activties of CRHSE

It is observed that presently CRHSE is involved in training activities at six levels:

- training of local youth and local leadership
- traning local youth clubs in the 3 zones of their project area
- training of VLWs
- training as part of internship for students from formal educational institutions eg. professional Social Work Institutions, students from Medical colleges, students from Seminary and Theological colleges.
- placement for trainees from Development Training Institutions eg. AIRD, SEARCH
- training for other NGO groups from within and outside Tamil nadu.

2. Building of Local Cadres

It is observed that it is relevant, crucial and very significant to utilise the expertise and the resoruces available at CRHSE to train the first 3 categories of people and groups for it is directly related to the primary objectives of CRHSE. On the one hand, strengthening of the local cadres through these trainings would further strengthen and would consolidate the main line programme of CRHSE on the other hand. It is strongly recommended that this area should recieve topmost priority at CRHSE and greater time and efforts should be made available in a systamatic manner to strengthen the area of training local leadership.

2. 1 Recommendations

It may be also recommended that the 'Social Education Sub zonal Coordinators if they are appointed and the Communication Team should play a very active role in this area. It could also be recommended that some staff who may be likely to be assigned a primary role in this regard should be adequately equipped to play a trainer role and CRHSE could consider sending such staff for advanced courses that would equiip him or her to perform in this role more effectively.

3. Internship for formal Education Institutions

With reference to the next three categroeis of training, we wish to make certain observations:

With regard to Internship Programme, particularly for formal educational institution preparing people for professional life – be it Medicine, professional Social work or fo priestly duties – greater caution is required.

Firstly, one has to consider the utilitarian value of such internships. Secondly, the time spent, partly in arranging the logistics and in interacting with these people, against the pres cribed work allotment of Coordinators and Sub zonal Coordinaaors is also to be taken into account. As it is observed presently, both the categories of staff are overworked – and therefore if time is frequently spent on internship trainees, then naturally it would affect adversely the functioning of CRHSE. On the other hand, if feedback availabe on the earlier Internship Programmes, indicates that it is merely a ritual of the part of these institutions to send their students for so called 'exposures' then perhaps, the results are discouraging and CRHSE may have to review its policy in this direction.

4. Placement Service for Development Agencies

With regard to accepting placement services from Development Training Institutions, it is observed that CRHSE is fulfilling a very vital role. If the model adopted by CRHSE, namely an alterantive health care system, were to be replicated, and it has to be replicated, the channel and form of exposure of this model, would be, though these placement services.

However here again, the same principle that we observd in the above said category is applied, with reference to the priority of CRHSE staff between implementation of a field programme, versus, guiding field placement trainees and if it is tilted to the benefit of the latter then, CRHSE would be rejecting itsprimary task. Therefore,it is felt that CRHSE should be judicious in considering requests for placements even from 'Develcpment Training Institutions'.

5. Direct Training Services to Other Development Groups

With regard to the last category of training, namely training other voluntary organisation both from Tamilnadu and from outside Tamil nadu, it is recommended to the policy makers of CRHSE to review whether this would fall under the primary scope of CRHSE and, if it is not so, presently, whether CRHSE would enlarge its scope to include this category of training under its purview.

6. Observations

Looking at the aspect of training in its totaltty, it is observed that consciously or unconsciously, or may be even due to extraneous needs and demands, the tilt in the training sector has been predominantly on the latter part of the above mentioned six categories – namely Internship, field placement and training of other groups. While training of VLWs is a vital and integral part of the programme, the same priority has not been accorded to the first categoires of local youth and leadership which are directly related to the primary goals and tasks of CRHSE.

7. Role - Ambiguity

Therefore, it is observed that very tentatively, it could be hypothesised that – - CRHSE as an organisation is undergoing role ambiguity in this context for, one could see and clearly demarcate distinctive roles of direct field work at a micro level, and in direct support services at a macro level. What CRHSE is attempting, is a combination of the two, perhaps unknowingly. Therefore, it is suggested that CRHSE could examine this hypothesis and take policy decisions in terms of whether CRHSE would see its role as a macro-service centre or, it would consolidate its role and functions as a micro field based unit. An attempt to combine the two would lead role ambiguity and the inherent contradictions would eventually cause both the programmes to suffer.

CHAPTER IX

Future Directions

1. Historical Milestones in CRHSE's Growth

CRHSE's growth can be viewed in four different stages namely, explorative stage, programme formulation and implementation stage, consolidation stage and zonalisation stage.

1. 1. Explorative Stage

When CHRSE began in 1978 the first one year was spent in exploring the areas of work, gathering data directly from the people through a participatory approach in relation to social, economic and political realities of the area. These data were analysed and basic premises and assumptions were inferred. Simultaneously, another process was also set in motion. It was a core team which lived with the people testing out for themselves their 'motivation' for this kind of work and coming together consciously as a team to commit for the task of working with people. This one year explorative stage was important in the members' jelling together as a team and identifying with the people directly and thereby getting in touch with realities.

1. 2. Programme formation and implementation Stage

The second stage can be identified between '79 and '82 during which data gathered during the previous year was translated into programmes. These programmes were tested and gradually the programmes were evolved and implemented during the later part of this stage.

1. 3. Consolidation stage

This occured during 82–83 when CRHSE reviewed its prgorammes took stock and consolidated it's work.

1. 4. Zonalisation:

The current stage can be described as the 'decentralisation phase' or 'zonalisation stage' which began in 1984. Reviewing this hostorical growth of CHRSE in terms of it's programmes and the growth of CRHSE as an organisation, one must acknowledge that the accomplishments are remarkable.

Zonalisation process should also be viewed from a different context.

2. Model of Zonalisation

While CRHSE's growth has been gradual, it's expansion was both logical and systamatic culminating to the present stage of decentralisation. This should be assessed as a critical stage in the devclopment of CRHSE for, a project working at a given geographical area with a population as adopted by CRHSE may beyond a point of time, become a liability rather than contri-

bute to the development and growth of the people in that area; survival of the project for its own existence' sake becomes critical. Secondly, it also leads to stagnation of the growth potential of the staff. Thirldy, from an organisational angel, it may lead to saturation point and as a result frustration may accumulate leading to disintegration of the organisation. Evaluating CRHSE model of zonalisation process against this background, provides insight into the ability of the leadership to acknowledge the above mentioned dangers and adopt this model. This model should be studied and is recommended to be replicated among other projects for the following reasons:

3. Strengths of Zonalisation Process

The zonalisation process acknowledges, to begin with, the second line leadership and provides opportunity for the growth of the second line leadership. Secondly, the expansion of programmes revolves around the nuclues of each zone and gradually shifts the leadership from the centre of the organisation to the respective zones which will definitely have a multiple effect on the impact of the programme in the area.

4. Speculations about future growth of CRHSE

Continuing further, from the aforementioned point, while fully acknowledging the strength of this model, one should also be aware of it's probable logical conclusions. In this process, in the course of time, the central office or the 'resourcement centre' will gradually become redundant and which has been *consciously* and *deliberately* planned by the project leadership. It is probable, due to an unconscious process, the organisational centre might grow in other directions in order to fill the vacuum that has been consciously created. Referrin,g to the preceding chapter under the heading 'Note on Training'. It was observed, that CRHSE is inclined to lean in the direction of becoming a 'macro-support service centre'. In such an event, the field bases will naturally provide the technical knowhow and the operational infrastructure for the macro service centre whereas it is assumed that, the primary objective of the zone is not to provide such an infrastructure for a 'macro-structure'. Therefore there will be 'goal incompatibilities' in terms of 'organisational growth' and 'operational programmes'.

5. Model of withering away Prccess

Therefore, our suggestions would be that the future direction of CRHSE, if it resolves it's organisational role ambiguity, then the prograrnmes at the zones can be intensified and the villages covered under each zone can be gradually expanded, incorporating the suggestions mentioned in this report relating to Social Education Programme. If CRHSE intensifies the SEP, in the respective zones, and the 'operationalised programmes of SEP will naturally strengthen the people's organisation which has been clearly found to exist, though not very strong. Zonalisation process can lead to linking up of all these peoples' organisations in each of the zones and newtorking of these peoples' organisations at a district level. This may also lead to 'peoples movement' and allow it to take it's own '*logical course of action*'. Thus the process of withering away evolved at tee central level can be replicated at the zonal level and gradually the focus can be shifted from the zona to the peoples organisations and to the emerging leadership - the concommitant factor of the aforementioned process.

6. Reference to the Original Objective of Crhse

It is pertinent to remind here that the aforementioned observations are the original objectives of CRHSE. We reproduce below extracts from 'Yonder the Hills' wherein the objectives of CRHSE have been articulated very clearly.

"Hence, our goal in this aspect of our project is to organise landless labour and poor peasants.. we see it is equally important to like up and Integrate their activities to a large net–work of similar labour movements so that this most exploited and unorganised section of our society, it's selfhood and collective expression by participation in a process of social transformation".

"i. Social Education Programme:

Education in basic communities such as the ones in Tirupattur is not so much a matter of reading and writing a language, but education for life itself. This can be achieved only through a certain type of functional literacy programmes. What is meant by functional literacy here is an educaitonal programme in which the labourers learn through their problems the basic mechanics of their society itself. In this way they will acquire a framework in which such facts of their life as exploitation, causes of poverty, ill-health, patterns of capital and land ownership, labour relations and rights of citizens, etc. become demystified and begin to be seen as being capable of being changed through appropriate collective action. Only this type of education can enable leadership to emerge from among these communities for the process of the transformation of their societies.

ii. Forming Unions of Agricultural Labourers:

The strength of the people becomes a reality primarily in this unity, and this is especially so in rural agricultural area. Unlike the modern industrial and urban sectors which are organised, the rural agricultural sector remains largely unorganised. This is a calamity in a developing countty like ours. Hence, this programme will endeavour to form unions of the landless labourers at village levels as a means of consolidating their power and strengthening them in their efforts to establish their rightful place in the field of agricultural production and to set up models of collective ownership and production. . ."

Therefore it is imperative while planning for future, and it is logical to refer back to the original objectives of the organisation.

7. Ultimate withdrawal of the project

Though we are all conscious that a project can not go on and on, yet, on the one hand we are not clear about when to stop, where to stop, and how to stop. On the other hand, without a clear understanding, 'withdrawing' for the sake of withdrawal either due to non availability of funds, for the programmes or due to various other reasons, will be incomplete and may be even harmful.

Though no one has the clear answers and no clear model is available to study, we certainly do have the examples of the 'gorwh pattern' of projects, in several parts of the country wherein the growth is in terms of the 'project as an organisation'. In most of these cases, the growth has been accidental and even unconscious. In other words, the growth occurs first and the rationalisation takes place later.

8. Challenge before CRHSE

In this context, it is suggested that it is almost a challenge posed before CRHSE to set in a process which can be a significant example for others to follow a 'conscious process of an ultimate withdrawal of a project' – which at the same time takes into account and plans for the sustenance of the process created by the project during the years of its hard work.

CHAPTER X

Epilogue

1. Conventional Reporting

It is customary that an evaluation report carries a chapter on 'Main Findings' which spells out A to Z the main findings. It is also customary to add a chapter called 'Summary Report' which condenses the entire report in a capsule form.

2. Pitfalls

The danger in the aforementioned 'customary' practices is that due to pressure of work and time, one has a tendency to read only those two chapters or contents under those two headings and may feel that they have understood the contents of the evaluation report. It will be very misleading, for we strongly believe that if one sincerely believes in reading an evaluation report, it has to be read in 'it's *entirety*'. In the present report we have specifically mentioned our observations, inferences and suggestions throughout the report, but it has always been against a frame of reference and, if one takes the inferences out of the reference, then the meaning will belost. There fore this report does not contain a chapter on Main findings.

3. Contextual Reference

To conclude, it is pertinent to reflect on two aspects at this juncture – firstly the premises stated in the preamble of this report and secondly on the classification of the nature of observations mentioned under the heading 'Nature and classificatoin of Assessment' Against such a frame of reference, we have persistently maintained that evaluation sets in a process helping the members of the organisation to review the objectives and goals of their organisation, and assess their accomplishments against the goals. It is also to enable them to become aware of their strengths and weaknesses and to assist them to formulate certain hypotheses, based on data gathered during the evaluation and to motivate them to test the same. And lastly, to test the hypotheses formulated during the process of evaluation and draw lessons and inferences from these testings.

4. Summing up

Therefore, the process of evaluation is only a beginning and stimulates the members of the organisation to continue the *process to it's logical ends.* If our experiences with the project leadership and staff during the evaluation were to be taken as an indicator, we are certain that this report will be used in this context by the organisation and *that is* and *should be* the objective of an evaluation.

ANNEXURE II

FRAME OF REFERENCE FOR THE EVALUATION OF CRHSE, TIRUPATTUR, INDIA

1. To examine how far the *aims and objectives* have been translated into programmes of action, and to find out if the objectives continue to be relevant, or if the changes taking place over the years in the project, is there any need for rethinking on the objectives.

   (The objectives for Social Education has not been clearly worded; practice is also different from the objective)

2. To study carefully the actual *process of the programme* specifically,

   * General Programme – Clinical Health
     Preventive & Promotional Health
     Health Education
     Training of Village Level Workers
     Social Education
     Organisation of Development Groups
     Subzonal Level Work
     Zonal Level Work
   * Siddha Health Project
   * Extension Programmes (now part of zonal programmes)
   * Training for Local Groups
   * Training for Other Groups – including District Organisation
     Group Meetings – Their response as to their benefit
   * Communication Team & Media Training

   and to find out if the programming is in keeping with the objective and the local conditions, and to evaluate the *work* of CRHSE and also to suggest possible improvements, if any.

3. a. To evaluate how the programme has been accepted by the *community*, and to see how far the community is involved in the programme.

   b. Also to seek answers to questions such as:
      i. if people really feel that they are participating in development;
      ii. if they feel there is phenomenal difference in their lives, with the introduction
      iii. how far people have realised that the standard of health is not the only yardstick, but the quality of awareness of themselves and their context (the possiblitilty or impossibility of transferring and/or transcending their realities as individuals and as a community;
      iv. How far community health programming can bring about social change;

4. a. To examine the *administrative system* as to find out how far the programme has been *facilitated* through the infra-structure that is available, and also to examine the feasibility of providing other facilities such as Polyclinic, Training Centre etc.
   b. to also examine the *financial aspects* of the programme and to find out if there is return for the moneys spent (not necessarily cost effective study) and also to see how far the self-supporting aspect of CRHSE's programmes have been realised (patients paying for their own medicines, VLW support, community support etc.)

5. To examine the role of the *organisational structure,* (to see how far the organisational structure has been helpful or hindred) in implementing the objectives with special reference to the new plan of zonalisation, and to find out if the decentralisation structure provides an alternative in administering voluntary development projects and in keeping with the wider philosophy of development.

6. To analyse the *staffing* of the project and to see how far they have responded to the requirements of the project, to also examine the quality of training offered to them in executing the project objectives and also to assess the future requirements of staff and the adequacy of their compensation.

7. To see what is the impact of this programme on other institutions (within the project area or elsewhere), agencies, Government departments, and other vested interests in this area. Has this programme affected in any way their attitude to people in the community. What have they learnt or what have they contributed to the life of the project.

Note on Frame of Reference

Despite the fact that the frame of reference was worked out between the donor agencies and the project holder, it was agreed during the '*preliminary meeting*' held between the evaluators, project holder and the donor agency representative at Bangalore that the Evaluators could feel absolutely free to modify, alter and shift the focus if such a necessity arose during the course of conducting the evaluation.

APPENDIX II

FOOTNOTES SUPPLIED BY CRHSE

P. 4. AUTONOMOUS VLWS

Till late 1985 all functioning VLWs were given a monthly stipend and medical supplies from the CRHSE. Since then the batches who had completed training upto 1983 are expected to be responsible directly to their villages. These are referred to as Autonomous VLWs. CRHSE continues to provide refresher programmes and to sell them medicines at cost price. The details of autonomy were decided in consultation with the VLWs. The details of future autonomisation are also being worked out.

P. 13. ASSOCIATION FOR RURAL HEALTH EDUCATION AND DEVELOPMENT

(Formerly KARUNA MEMORIAL SOCIETY) was an orphanage -cum-skill training Centre run by the above said Association for the rural poor of Sathiamathapuram area. At their request CRHSE deputed a staff there and designed and coordinated the health programme. In 1984 this extension programme was incorporated as one of the subzones of Vaniyambadi Zone. The work within this subzone did not spread radically because the geographical situation of the area (between the hills and the main road) has resulted in villages spreading in almost on a straight line.

P. 16. CHILD TO CHILD PROGRAMME

This was started in 1984 in Athanavur High School on Yelagiri Hills. The subzonal coordinator perepared a simple syllabus and with the Headmaster's permission to take one class every alternate week, trained 10 children from different villages over a period of one year.

P. 17. TRAINING OF COMMUNICATION TEAM

Santhosh spent two weeks in Calcutta for a Rural Communication Course run by LWS in 1983. He went to Delhi (1981-1982) for a three-month training programme in Health Education at the Central Health Education Bureau. 6 VLWs went to People's Theatre, Ikkadu & Navayuga, Madras for Communication skill training courses. The communication Team designs and conducts its own programmes for staff and VLWs and this experience has served as a learning ground for those who have not had these formal and institutional types of training. Frequent weekend zonal communication training programmes have been organised by Mr. Santhosh.

P. 18. CULTURAL TALENT FESTIVAL (MEDIA TALENT COMPETITION)

In 1985 the communication team conducted a cultural festival to develop skills in various communication media competitively. Plays, songs, flash-cards, posters were among the media explored. This was a three day programme involving over 80 VLWs and all 20 Staff. (including Siddha Division).

P. 21. CHOLERA EPIDEMIC

In July 1985 a cholera epidemic hit Vaniyambadi. The CRHSE contacted the Municipal Health Officer and assisted the authorities by carrying out public awareness programmes to tell people to avail of immunisation facilities. In remote areas 20 immunisations were conducted using vaccines supplied by the MHO.

P. 24. VLW DROP-OUT RATE

SEX	MALE							FEMALE							
Age at joining	<25 yrs		>25 yrs		>30 yrs		Total	<25 yrs		>25yrs		>30yrs		Total	GTotal
Marital Status	M	Um	M	Um	M	Um		M	Um	M	Um	M	Um		
Total	3	7	3	1	5	0	19	12	8	18	1	11	0	50	69
Drop-out	0	1	0	0	0	0	0	4	2	1	1	1	0	9	10
Promoted	0	1	0	0	0	0	1	0	2	0	0	0	0	2	3

P. 32. EXAMINERS

The present system actually involves Dr. V. Benjamin (Vice-President of CRHSE Association) Dr. Sadiq (the Medical Consultant) and the respective Zonal and/or Subzonal Coordinators in the examination & testing. CRHSE found the observation of the Evaluation Team significant and will include an independent medical person in the process in future.

P. 49. YOUTH & WOMEN'S GROUPS

a. (v) Kathirampatti — Y & W

(vi) Chettipattarai — W

(vii) Narianeri — NIL

P. 50. WAGE RISE

In 1978 the daily wage in Vallipattu area was Rs. 3/- for men and Rs. 1.50 for women. With the emergence of the YRSC (Youth Groups) the wages were raised to Rs. 3.50 & Rs. 2.00. At present it is Rs. 7.00 and Rs. 5.00.

P. 51. SOCIAL ACTION: VALLIPATTU

Food For Worth was arranged; Chandrapuram Women's Group has got the government to established a bore well; electricity assisted people to get one-light hut service under the government scheme; quarry workers boycotted work in 1985 to get a wage rise in Kadirampatti; removal of the "separate glass" restriction in Jayapuram (1979–80) and Bommikuppam, Parthenium

Eradication Camps in 1985 with environmental action where villages in Jayapuram Zone took out action, and followed up at Athanavur on the hills and Thimmanamathur, Bommi kuppam villagers (with CRHSE support) approached authorities for land pattas (1976–80); meeting between government officials and local people to voice griewiences, assistance in getting government and bank loans to people, Sowydakuppam Women's Group procession to BDO to seek self-employment facilities; Drama on wage question: followed by meeting with a Pudupungulam plant nursary owner which resulted in a wage hike :

P. 67. VISITS TO AND VISITS FROM OTHER ORGANISATION

CRHSE STAFF TEAM VISITING OTHER ORGANISATIONS 1984-1985

1.	Sathish Samuel to National Institute for Rural Development, Hydrabad Research Orientation on People's Participation ..	1984
2.	D. Santhosh Rural Development Seva Centre ..	1984
3.	P. Rajagopal RCPED, Madurai to attend a seminar on Srilankan Tamil Problem ..	January, 1984
4.	Sathish Samuel and P. Rajagopal Community Health and Education Programme Thirumurthynagar, Coimbatore District ..	1984
5.	A five member CRHSE staff team to Rural Theological Institute ..	22-06-85 — 24-06-85
6.	K. Thenmozhi Training Course on "Women & Development" CHDSC, Madras ..	19-08-85 — 31-08-85
7.	Rajagopal Course on Finance, Accountancy and Legal Aspects, CDS, Bombay ..	04-08-85 — 11-08-85
8.	A four member CRHSE staff team to the Dalit Facilitation Centre Groups at Kasam & Shanti ..	10-12-85
9	A five member CRHSE staff team to the Dalit Facilitation Centre Groups at Salem Law College ..	29-12-85

10.	D. Santhosh and Muniappan People's Integrated Development Project Salem District To conduct a health seminar	..	1985
11.	Azeez Khan & K. Thenmozhi Seminar for the International Year of Peace, Madurai – SSI	..	07-04-86 — 09-04-86
12.	Selvarani Santhosh and M. Vijaya Consultation on "Women & Health" CMAI, ECC & AIWCC, Bangalore	..	27-04-86 — 30-04-86

OTHER GROUPS VISITING CRHSE 1984-1985

1.	A two member staff team from SPHERE, Gooty, Andhra Pradesh	..	01-04-84 — 04-04-84
2.	A three member staff team from Bangalore Baptist Hospital	..	29-08-84 — 31-08-84
3.	A two member team from Pulicat Lake Fisherman's Project	..	03-09-84 — 08-09-84
4.	A eleven member team from Madras Christian Council of Social Service	..	06-09-84
5.	A two member staff team from Centre for Rural Reconstruction through Social Action, Akividu, Andhra Pradesh	..	10-10-84 — 16-10-84
6.	A two member team from INGRID, Raichur, Karnataka	..	11-01-85 — 12-01-85
7.	A six member team from WIDA, Orissa	..	22-02-85 — 27-02-85
8.	A two member staff team from People's Theatre, Ikkadu	..	11-09-85
9.	A one member placement trainee from Anthyodiya Sangh, Tiruchy	..	15-10-85 — 14-11-85
10.	A five member volunteers team from People's Theatre, Ikkadu	..	02-11-85 — 06-11-85
11.	A twentiy four member women volunteers team from Roshanagaram Rural Institutions Programme	..	20-11-85 — 22-11-85

RESPONSE TO THE EVALUATION

After going through the Evaluation Team's report, and suggesting some additional information that should be provided for footnotes, there was a discussion on the opinions raised in the report and its recommendations. This is the first major external appraisal of CRHSE work and it has raised many valuable points.

1. The CRHSE has not yet explored the possibility of using the 16 mm films available with the government for health education purposes.

2. The CRHSE needs to reflect on the suggestion that VLWs lack awareness on the preventive side. There is a need to test whether this is really so and to fill in any gaps in the training programme. It has been premised that the ANM and CHG training acquired outside did not focus adequately on the health trainer's role. The CRHSE has nearly 6 years experience in this field and would like to use the knowledge gained to upgrade the teaching techniques of its own subzonal coordinators.

3. The Evaluation Team has rightly asked about the plans for TB, VD and leprosy coverage. Despite our original plans we have not started intensive work (though, periodic Community Screening Programmes are conducted) in any of these three areas. The matter must be taken up immediately.

4. The staff considered the Evaluation Teams concept of Subzonal Social Education Coordinators, and it was thought that in each Zone only one community organiser could be introduced in order to organise social education and action programmes. He/She would also coordinate the zonal communication team. He/She would report to the zonal coordinator. This plan would mean the addition of only 3 new staff instead of the Evaluation Teams' suggestion of 10.

5. The suggestion to get feedback data from those who are not coming to the clinics was well appreciated. This was in fact a component of one of the Terms of Reference (No. 3) for the Evaluation Team. We hope the Evaluation Team will include a note on their findings in this respect in the final report. It seems to have been left out of the draft report.

6. The question of parameters to measure the effects of health education needs reworking since CRHSE does not subscribe to the KAP study method commonly used by a professional-health institution. More concrete results such as health gains might be measured. The Evaluation Team has constantly referred back to the original aims and objectives. It is important to note that following itnernal evaluation – especially the major effort that was undertaken in 1983 the CRHSE has (as detailed in the annual reports) introduced many new thrusts and significantly altered old ones.

ZONALISATION

Division into 3 Zones was done in oder to lessen the load on a small central group which was coordinaing all the work till then. The old team was split among the zones and each zone was given powers that were ealier held by the Centre. This decentralisation has been a great gain. It also reflects the democratic philosophy and an ideological plan of the Project.

RESOURCEMENT & TRAINING

This was one of the incidental objectives laid down in 1979.It was been going on continuously. Each zone, as well as the Cente undertakes training and reviews. At least 20 major programmes occured within CRHSE in 1985 alone. The finance for these programmes would be enormous if they were held in rented halls. Fortunately our own RTC is ewll-suited to hold these programmes. We also rent the RTC for programmes by visiting groups and this helps in its maintenauce.

ATTITUDE TO SOCIAL EDUCATION

In the early 1980s drought prevailed in Tamilnadu. The social philosophy of CRHSE was extremely meaningful and yielded great gains (The wage rise and organising food for work programmes in Vallipattu area actually occurred in this time). However the Tirupattur region also witnessed an upsurge of extreme leftist activity around the same time (for much the same reason – poverty and hunger in the face of oppressoin). The government's response to this was quite sharp. The slightest hint of socialism was taken to the proof of Naxalitism. It did bring CRHSE under state surveillance. It was about this point in time that the drought came to an end and CRHSE was left with a choice between consolidating the health gains and leaving the area due to the interference that would result out of pushing socialist ideals at a very inopportun time (of great suspicion and mistrust). This is not an excuse, but in certainly is reason why the social education programmes look apparently retarded greatly between 1981 and 1984 but new strands of action emerged.

CONCEPT OF WITHDRAWAL

This was always a part of CRHSE's philosophy. However the specific details were not worked out and in 1983-1984 discussion about it was eclipsed by the efforts for Zonalisation. Now that the zones are stable it has become clear that the time has come for the senior VLWs to stand on their own feet, while a netwrok of now VLWs is built up in responding areas. This was the basis for the new Autonomous VLWs (see footnote on page 4).

The CRHSE staff who discussed the report found that they differed from the Evaluation Team in many places. These related to various value judgements passed. They submit the following view for consideration:

P. 17. They feel that the communication team has always worked on aspects of social education.

P. 19. The fact that the slides they have are prepared by "experts at professional institutions" does not make these slides the best suited to convey a health message to a rural population.

P. 24. The reasons for the "drop-out" phenomenon during the VLW course include lack of attendence, inability to cope with the course etc. This weeding out can be considered part of the selection process rather than a weakness.

P. 29 & 30. Medical Consultants: It is quite clear that the particular practitioner refered to is dedicated to the project. He was a full-time staff member even before setting up private practice and was very much involved in formulating the VLW training syllabus.

UNWARRANTED PRESCRIPTIONS

We asked a medicl intern who has been associated with our project for the past 4 years for his opinion He says:

"There has been a problem of this sort on and off in CRHSE. Polyprescription and unscientific prescribing were actually features that quite clearly arose at the time when Dr. Sadiq was not a staff member of CRHSE (1982-83) for a short period. Hence the reasons for this very real problem must be found elsewhere. The Evaluation Teams views on private practice are generalizations and do not apply to the specific CRHSE situation."

P. 30. CRHSE has always planned to decrease the dependence on the medical consultant and increase the use of subzonal coordinators and VLWs to an optimal degree.

P. 37. The calculation about the use of subzonal coordinators and of other health practitioners appears to be on a bypothetical basis. The evaulation team (vide terms of reference 3) could have evaluated this concretely.

P. 37. The subzonal coordinators visit one VLW every day by rotation. We cannot imagine a closer link than this.

P. 43. This hypothesis may, in fact, explain the successes of the CRHSE to date However, we do not yet advocate such a method as a policy.

P. 67. The Evaluation Team speaks of "the absence of exposure based reflection". Except the driver and the administrative assistants every staff member and VLW is field-based. (and hence exposed). As far as reflection goes: There are 3 Grand Staff Meetings each year to review our work and plan new directions. Similarly each zone holds 12 staff meetings year and atleast 4 VLWs meetings for reflection and planning.

P. 76. The Report constantly emphasizes the "need" for increasing the training input from formal training institutions and the need to stop giving placements and informal training to outsiders as this will result in "rolo ambiguity".

We feel that learning is a tow way process. We both teach and learn from placement persons. Our staff study both in hospitals and training programmes but they also have some thing to teach such resource centres from their practical experience.

Part III

Base Line Survey - An Initiative

By

Staff And Village Level Workers

Edited by

Prabir Chatterjee

INTRODUCTION

The Baseline Survey was first mooted in 1986 as a part of an ongoing internal evaluation in CRHSE. It really got off the ground in 1987 when Village Level Workers and staff surveyed 31 villages in the areas of our work.

By December we had held analysis meetinsgs in all three zones and the results are summarised in the following tables. In all, the figures for some 12 villages have been looked at and converted to universally acceptable statistics. This work was done by those who undertook the survey: that is, the VLWs themselves in most cases. This does mean that it takes a long time but since the meaning of the survey will become apparent to the VLW, it will be of much more use than the usual non-participatory research papers that adorn so many libraries.

AREA - A

Previously Uncovered	**Jayapuram Zone**
Birth Rate	22.19/1000
Infant Mortality	0/30
Total Population	1353
Still Birth Rate	0/30
ANC	58.09%
Death Rate	?
Fertility of 20 to 49 age group women	128/1000
Under Fives	
Immunisaion coverage (Male)	6.86%
Immunisation Coverage (Female)	1.33%
Normal Nutrition	19.6%
Grade I Malnutrition	18.6%
Grade II Malnutrition	41.2%
Grade III and Below	19.6%

	Karadi Goundanoor	Mottur	Muthampatti	West Vadanaviadi	Thunganoor	Total
Children born In Past Year	6	7	4	10	3	30
Infant Deaths	0	0	0	0	0	–
Total Deaths	–	–	–	–	–	–
Still Birth	0	0	0	0	0	0
ANC	3	5	2	5	3	18
Women Aged 20 to 49	40	80	60	68	47	235
Females	84	170	144	159	112	669
Males	74	185	144	167	114	684
U/5 Males	8	24	18	30	9	89
U/5 Females	9	21	15	22	8	75
Unimmunised U/5 Males	7	24	18	25	9	83
Unimmunised U/5 Females	9	21	15	21	8	75

NUTRITION

Grade I	3	5	5	2	5	20
Grade II	1	21	7	12	4	45
Grade III	5	4	2	5	5	21
Normal	3	5	6	2	5	21

AREA - B

Covered since 1984	Vaniyambadi zone
Birth Rate	27.41/1000
Infant Mortality	121.2/1000
Total Population	2444
Still Birth Rate	70.48/1000
ANC	50.64%
Death Rate	7.36/1000
Fertility of 20 to 49 age group women	125.5/1000
Sex Ratio	879/1000

Under Fives

Immunisation Coverage (Male)	48.92%
Immunisation Coverage (Female)	46.12%
Normal Nutrition	38.63%
Grade I Nutrition	22.74%
Grade II Nutrition	26.13%
Grade III Nutrition	12.50%

	Neckna-malai	Sokkam-pallam	Moola-kollai	Lalayeri	Pudur	Purushothuma kuppam	Total
Children Born in Past Year	18	6	1	8	16	17	66
Infant Deaths	1	0	0	4	3	0	8
Total Deaths	1	0	0	13	4	0	18
Still Birth	1	1	0	3	0	0	5
ANC	15	6	1	5	13	16	56
Women Aged 20 to 49	139	111	21	66	115	74	526
Total Males	299	286	55	155	316	190	1301
Total Females	277	261	53	152	262	138	1143
U/5 Males	38	22	5	21	35	23	144
U/5 Females	23	33	9	18	22	15	120
Unimmunised U/5 Males	32	15	1	1	17	5	71
Unimmunised U/5 Females	21	29	1	0	10	3	64
NUTRITION							
Grade I	7	9	3	10	10	8	47
Grade II	9	7	2	14	6	17	55
Grade III	6	4	2	2	6	8	28
Normal	39	31	7	10	16	4	107

The results so far have been from two distinct areas which are shown in the tables as Area-A and Area-B.

When looking at them the first noticeable difference is in the infant mortality rates. The statistics show no infant deaths in Area-A. This is being checked out. The new statistics show an infant mortality rate which is around 70/1000 live births. Two factors have to be taken into consideration. Firstly that Area-A has relatively fertile land with greater agricultural productivity. The second is that some of the poor families in this area migrate to Bangalore for work and hence some of the data on infant deaths may not be recorded as occuring in the villages though the mothers usually return to their home villages for delivery and so all births will be recorded.

The still-birth rates need to be similarly rechecked as well as the death rate.

In terms of immunisation coverage we find that Area-B is much better off. However even here the coverage (which only considers first dose) is much lower than that recorded for the block as a whole by other investigators. 50% immunisation (first dose) is very poor by any standards. In fact when the WHO in May 1988 called for 70% coverage in polio immunisations - they were talking about 70% completion of the schedule. Areas like Necknamalai (which can only be reached by walking two to three kilometres uphill) need special attention in this respect. However improvement in transport and communications could work wonders that years of dedicated effort might not be able to achieve.

Area-A is at a distinct disadvantage in Nutrition. This is despite the overall high agricultural productively. Though Production may be important in preventing mortality: Distribution is the most important factor in preventing Malnutrition. One might say that production ensures Quantity of life and distribution ensures Quality of life.

This study now requires a comparative area in which CRHSE has been working since 1978 to see whether the organisation's social and health awareness programmes have in fact led to improvements that can be measured as health gains. The survey in this Area-C has already been done and the process of analysis is going on. We eagerly await the results.

"Each time a man stands up for an ideal or acts to improve the lot of the down-trodden and oppressed, or strikes against injustice, he sends forth a tiny ripple of hope, and crossing each other from a million different centres of energy and daring, those ripples build a current that can sweep down the mightiest walls of oppression."

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